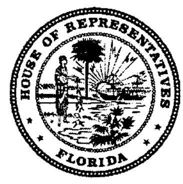
Insurance & Banking Subcommittee

Wednesday, March 18, 2015
8:00 AM
Sumner Hall (404 HOB)

MEETING PACKET

Steve Crisafulli
Speaker

John Wood
Chair



The Florida House of Representatives

Regulatory Affairs Committee

Insurance & Banking Subcommittee

Steve Crisafulli
Speaker

John Wood
Chair

AGENDA

Wednesday, March 18, 2015
404 HOB
8:00 am – 11:00 am

I. Call to Order

II. Roll Call

III. Consideration of the following bill(s):

a. HB 681 Health Insurance Coverage for Emergency Services by Trujillo
b. CS/HB 731 Employee Health Care Plans by Health Innovation Subcommittee; Plakon
c. HB 749 Continuing Care Communities by Van Zant
d. HB 1025 Firesafety for Agricultural Buildings by Raburn, Combee
e. HB 1053 Motor Vehicle Insurance by Fant
f. HB 1133 Division of Insurance Agent and Agency Services by Fant
g. HB 7047 Direct Primary Care by Health Innovation Subcommittee, Costello
h. PCS for HB 669 Insurance Claims
i. PCS for HB 895 Flood Insurance
j. PCS for HB 1013 Maximum Reimbursement Allowances for Workers' Compensation Medical Services

IV. Adjournment

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Insurance & Banking Subcommittee

Start Date and Time: Wednesday, March 18, 2015 08:00 am

End Date and Time: Wednesday, March 18, 2015 11:00 am

Location: Sumner Hall (404 HOB)

Duration: 3.00 hrs

Consideration of the following bill(s):

HB 681 Health Insurance Coverage for Emergency Services by Trujillo
CS/HB 731 Employee Health Care Plans by Health Innovation Subcommittee, Plakon
HB 749 Continuing Care Communities by Van Zant
HB 1025 Firesafety for Agricultural Buildings by Raburn, Combee
HB 1053 Motor Vehicle Insurance by Fant
HB 1133 Division of Insurance Agent and Agency Services by Fant
HB 7047 Direct Primary Care by Health Innovation Subcommittee, Costello

Consideration of the following proposed committee substitute(s):

PCS for HB 669 -- Insurance Claims
PCS for HB 895 -- Flood Insurance
PCS for HB 1013 -- Maximum Reimbursement Allowances for Workers' Compensation Medical Services

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., Tuesday, March 17, 2015.

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., Tuesday, March 17, 2015.

NOTICE FINALIZED on 03/16/2015 16:21 by McCloskey.Michele

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 681 Health Insurance Coverage for Emergency Services
SPONSOR(S): Trujillo
TIED BILLS: **IDEN./SIM. BILLS:** SB 516

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Peterson KP	Cooper
2) Appropriations Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A Preferred Provider Organization (PPO) is a health plan that contracts with providers to create a network of providers who participate for an alternative or reduced rate of payment. Generally, the member is only responsible for required cost-sharing amounts if covered services are obtained from network providers. However, if a member chooses to obtain services from a non-network provider, those out-of-pocket costs likely will be higher. In an Exclusive Provider Organization (EPO) arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the contract hospitals or providers to receive covered benefits, subject to limited exceptions. A Health Maintenance Organization (HMO) provides health care services pursuant to contractual arrangements with preferred providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for non-network services rendered to the member.

Current law requires an HMO to provide coverage for emergency services and care without prior authorization and without regard for whether the provider has a contract with the HMO. The HMO must reimburse a noncontract provider the lesser of the provider's charges; the usual and customary rate for provider charges in the community; or the rate agreed to between the provider and the HMO. The noncontract provider may not collect addition reimbursement from the subscriber. An HMO must charge a subscriber the same copayments for emergency care whether the care is provided by a contract or noncontract provider.

The bill establishes a payment methodology for emergency services and care provided by noncontract providers to members of a PPO or EPO and prohibits those providers from collecting or attempting to collect any additional amount. Plans must reimburse non-network providers the greater of the median in-network rate; the usual and customary reimbursement, calculated using the plan's formula; or the Medicare rate. PPOs and EPOs are required to provide coverage for emergency care, including prehospital transport without prior authorization and regardless of whether the provider is in-network. Applicable cost-sharing must be the same for network or non-network providers.

In addition, the bill revises the methodology an HMO must use to reimburse non-network providers for emergency services and care to conform to the new methodology applicable to PPOs and EPOs. The effect is to change the existing reimbursement standard from one that is based on provider charges to one that is based on provider reimbursement.

The bill may have a fiscal impact on state government due to the change in reimbursement to HMOs for services provided to Medicaid beneficiaries. The bill will have a fiscal impact on those local governments that currently balance bill patients for ambulance services and may have a fiscal impact as a result of the required methodology for calculating non-network payments for services.

The bill is effective October 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Managed Care Organizations

Types[1]

Preferred Provider Organization (PPO)[2]

A PPO is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. A PPO is an insurance product. PPO plan members generally see specialists without prior referral or authorization from the insurer. Generally, the member is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network (contract) providers. However, if a member chooses to obtain services from a non-network (noncontract) provider, those out-of-pocket costs likely will be higher. An insurer that offers a PPO plan must make its current list of preferred providers available to its members.

Exclusive Provider Organization (EPO)[3]

In an EPO arrangement, an insurance company contracts with hospitals, physicians, and other medical facilities. Insured members must use the contract hospitals or providers to receive covered benefits, subject to limited exceptions.

Health Maintenance Organization (HMO)[4]

An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area. The network is made up of providers who have agreed to supply services to members at pre-negotiated rates. Traditionally, an HMO member must use the HMO's network of health care providers in order for the HMO to make payment of benefits. The use of a health care provider outside the HMO's network generally results in the HMO limiting or denying the payment of benefits for non-network services rendered to the member.[5]

Regulation

The Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations, and other risk-bearing entities.[6] To operate in Florida, an HMO must obtain a certificate of authority from OIR.[7] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA pursuant to part III of ch. 641, F.S.[8] As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[9]

---

[1] *See generally* FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers, available at*: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Commercial_Managed_Care/chmo.shtml (last visited March 8, 2015).
[2] *See generally* s. 627.6471, F.S.
[3] *See generally* s. 627.6472, F.S.
[4] *See generally* part I of chapter 641, F.S.
[5] Section 641.31(38), F.S., creates an exception to this general rule. It authorizes an HMO to offer a point-of-service benefit. The benefit, offered pursuant to a rider, enables a subscriber to select, at the time of service and without referral, a noncontracted provider for a covered service. The HMO may require the subscriber to pay a reasonable co-payment for each visit for services provided by a noncontracted provider.
[6] s. 20.121(3)(a)1., F.S.
[7] ss. 641.21(1) and. 641.49, F.S.
[8] ss. 641.21(1) and 641.48, F.S.
[9] s. 641.495, F.S.

The Florida Insurance Code requires health insurers and HMOs to provide an outline of coverage or other information describing the benefits, coverages, and limitations of a policy or contract. This may include an outline of coverage describing the principal exclusions and limitations of the policy.[10]

Balance Billing[11]

Background

Balance billing describes the situation where a health care provider seeks to collect payment from a patient for the difference between the provider's billed charges for a covered service and the amount that the managed care organization paid on the claim. Before the rise of managed care, consumers with insurance typically expected some balance billing. Under traditional indemnity insurance, the insured paid the provider directly then sought reimbursement from the insurer. The insurer reimbursed, minus any cost sharing, up to the policy amount. If the reimbursement was below the billed charge, then the patient would not be fully reimbursed.

Today most people with private insurance are covered by a managed care organization. Members must utilize the services of network providers to minimize out-of-pocket expenses. Typically, contracts between network providers include a "hold harmless" provision that protects members from being balance billed by a network provider for covered services. In consenting to these provisions, participating providers generally agree not to seek reimbursement from a member beyond payment of applicable cost-sharing requirements, such as copayments, co-insurance, or deductibles.

A member may choose to seek care from a non-network provider, for example from a specialist regarded as an expert in the field. A member may utilize non-network providers unknowingly while receiving care at a network hospital. While radiologists, anesthesiologists, pathologists, and increasingly emergency room physicians are hospital-based physicians, generally they are not hospital employees and may or may not contract with the same MCOs as the hospital. Likewise, a member may receive—and be billed for—services from a non-network provider if the member's network physician consults with a non-network specialist. Finally, a member may receive non-network care from a non-network hospital as a result of an emergency transport.

An analysis conducted for the California HealthCare Foundation in 2006 of 1.2 million residents with employer-sponsored commercial (private) insurance found that almost 11 percent of those studied used non-network services at some point during the year. Most non-network utilization occurred as a result of a hospital admission, or an emergency department visit without admission. The average balance bill (across facilities, physicians, and other professional providers) was $1,289 in addition to the average patient cost-sharing amount of $433. The average balance bill for an inpatient admission averaged $6,812.[12]

Current Prohibitions on Balance Billing

Currently, balance billing is prohibited for services provided under the Medicaid program[13] and workers compensation insurance;[14] emergency services or by an exclusive provider who is part of an EPO.[15] In addition, the law provides that an HMO is liable to pay, and may not balance bill for, covered services provided to a subscriber whether or not a contract exists between the provider and the HMO.[16]

---

[10] s. 627.642, F.S.

[11] *See generally* CALIFORNIA HEALTHCARE FOUNDATION, *Unexpected Charges: What States Are Doing About Balance Billing* (April 2009), *available at* http://www.chcf.org/publications/2009/04/unexpected-charges-what-states-are-doing-about-balance-billing (last visited March 14, 2015).

[12] *Id.* at 4.

[13] s. 409.907(3)(j), F.S.; Medicaid managed care plans and their providers are required to comply with the Provider General Handbook, which expressly prohibits balance billing. In addition, the Statewide Medicaid Managed Care Contract (CORE contract) establishes minimum requirements for contracts between plans and providers. The CORE contract requires those contracts to prohibit balance billing, except for any applicable cost sharing. (E-mail from Josh Spagnola, Legislative Affairs Director, Florida Agency for Health Care Administration, excerpting relevant provisions from the Handbook and the CORE contract (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).

[14] s. 440.13(13(a), F.S.

[15] s. 627.6472(4)(c), F.S.

[16] ss. 641.315(1) and 641.3154(1), F.S.

However, the statute further qualifies the prohibition by saying that an HMO is liable for services rendered if the provider obtains authorization from the HMO prior to providing services. Thus, a provider can balance bill if authorization is denied or if the provider does not seek prior authorization.[17,18]

In the case of emergency services and care, an HMO is prohibited from requiring prior authorization.[19] Thus, the qualification related to authorization does not apply and balance billing is prohibited under the general provision of law.

Effect of Changes Related to Balance Billing
The bill establishes a payment methodology for emergency services and care provided by noncontract providers to members of a PPO or EPO and prohibits those providers from collecting or attempting to collect any additional amount. In effect, the bill prohibits these providers from balance billing, thereby applying the same prohibition to members of PPOs and EPOs as currently applies to members of an HMO.

Access to Emergency Services and Care

Hospital Care
In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. EMTALA imposes specific obligations on hospitals participating in the Medicare program which offer emergency services. Any patient who comes to the emergency department must be provided with a medical screening examination to determine if the patient has an emergency medical condition. If an emergency condition exists, the hospital must provide treatment within its service capability to stabilize the patient. If a hospital is unable to stabilize a patient, or if the patient requests, the hospital must transfer the patient to another appropriate facility.[20] A hospital that violates EMTALA is subject to civil money penalty;[21] termination of its Medicare agreement;[22] or civil suit by a patient who suffers personal harm.[23] EMTALA does not provide for civil action against a hospital's physicians.

Florida law imposes a similar duty.[24] The law requires the AHCA to maintain an inventory of the service capability of all licensed hospitals that provide emergency care in order to assist emergency medical services (EMS or ambulance) providers and the public in locating appropriate medical care. Hospitals must provide all listed services when requested, whether by a patient, an emergency medical services provider, or another hospital, regardless of the patient's ability to pay. If the hospital is at capacity or does not provide the requested emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services. Each hospital must ensure the services listed can be provided at all times either directly or through another hospital. A hospital is expressly prohibited from basing treatment and care on a patient's insurance status, economic status, or ability to pay. A hospital that violates Florida's access to care statute is subject to administrative penalties; denial, revocation, or suspension of its license; or civil action by another hospital or physician suffering financial loss. In addition, hospital administrative or medical staff are subject to civil suit by a patient who suffers personal harm; and may be found guilty of a second degree misdemeanor for a knowing or intentional

[17] *But see Joseph L. Riley Anesthesia Associates v. Stein*, 27 So. 3d 140, 145 (Fla. 5th DCA 2010). The Fifth DCA has held that an authorization issued to a contract provider for services (surgery) in a hospital is deemed an authorization for a hospital-based provider of medically necessary services (anesthesia) that are provided under an exclusive contract without regard for the existence of a contract with the HMO. In other words, if the main service is authorized, related services provided under an exclusive contract are deemed authorized and balance billing is prohibited.
[18] *See also* FLORIDA MEDICAL ASSOCIATION, *Balance Billing*, http://www.flmedical.org/LRC_Balance_billing.aspx (last visited March 15, 2015).
[19] s. 641.513(1)(a), F.S.
[20] Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §1395dd.; *see also* CENTERS FOR MEDICARE & MEDICAID SERVICES, *Emergency Medical Treatment & Labor Act (EMTALA)*, http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/ (last visited March 13, 2015).
[21] 42 U.S.C. § 1395dd(d)(1).
[22] 42 C.F.R. § 489.24(f).
[23] 42 U.S.C. § 1395dd(d)(2).
[24] *See* s. 395.1041, F.S.

violation. Physicians who violate the act are also subject to disciplinary action against their license; or civil action by another hospital or physician suffering financial loss.

Prehospital Care

The Emergency Medical Transportation Services Act[25] similarly regulates the services provided by emergency medical technicians, paramedics, and air and ground ambulances. The act establishes minimum standards for emergency medical services personnel, vehicles, services, and medical direction, and provides for monitoring of the quality of patient care. The standards are administered and enforced by the Department of Health. Ambulance services operate pursuant to a license issued by the department and a certificate of public convenience and necessity issued from each county in which the provider operates.[26] A licensee may not deny a person needed prehospital treatment or transport for an emergency medical condition.[27] A violation may result in denial, suspension, or revocation of a license; reprimand; or fine.[28]

In general, the medical director of an ambulance provider is responsible for issuing standing orders and protocols to the ambulance service provider to ensure that the patient is transported to a facility that offers a type and level of care appropriate to the patient's medical condition,[29] with separate protocols required for stroke patients.[30] An exception to the general requirement, trauma alerts patients are required by statute to be transported to an approved trauma center.[31]

State law establishes the provision of ambulance services as a core function of county government.[32] Counties may provide the service directly, under contract with one or more private or municipal providers, or both. Currently, 61 counties 97 municipalities are licensed to provide emergency medical services.[33] This represents more than half of all licensed providers.

Payment for Emergency Care and Services

Florida Law

A PPO must charge a member the same copayments for emergency care whether the care is provided by a contract or noncontract provider.[34]

An EPO plan must ensure that emergency care is available 24 hours a day and 7 days a week. Insurers issuing exclusive provider contracts must pay for services provided by non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.[35]

An HMO must provide coverage without prior authorization for prehospital transport or treatment or for emergency services and care[36] that is rendered by either a contract or noncontract provider.[37] An HMO must charge a subscriber the same copayments for emergency care whether the care is provided by a contract or noncontract provider.[38]

---

[25] Part III of chapter 401, F.S. (ss. 401.2101 – 401.465, F.S.)
[26] s. 401.25(2)(d), F.S.
[27] s. 401.45, F.S.
[28] s. 401.411, F.S.
[29] Rule 64J-1.004()(a), F.A.C.
[30] s. 395.3041(3), F.S.
[31] s. 395.4045, F.S.
[32] *See* s. 125.01(1)(e), F.S.; *see also* s. 155.22, F.S.
[33] Florida Department of Health, *EMS Provider Type Reports* (March 16, 2015) (on file with the House Insurance & Banking Subcommittee).
[34] s. 627.6405(4), F.S.
[35] s. 627.6472, F.S.
[36] "Emergency services and care" include the medical screening, examination, and evaluation to determine whether an emergency medical condition exists and the care, treatment, or surgery necessary to relieve or eliminate the emergency medical condition. (s. 641.47(8), F.S.)
[37] ss. 641.31(12) and 641.513(1)(a), F.S.
[38] s. 641.31097(4), F.S.

The law requires HMOs to pay noncontract providers specified minimum reimbursement for emergency services. Specifically, HMOs must reimburse providers the lesser of:[39]

- The provider's charges;
- The usual and customary provider charges for similar services provided in the community; or
- The charge mutually agreed to by the HMO and the provider.

Reimbursement is net of any applicable copayment.

HMOs must reimburse Medicaid providers of emergency care and services the lesser of:[40]

- The provider's charges;
- The usual and customary provider charges for similar services provided in the community;
- The charge mutually agreed to by the HMO and the provider; or.
- The Medicaid rate.

Patient Protection and Affordable Care Act

The federal PPACA was signed into law on March 23, 2010.[41] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, coverage for adult dependents, and other requirements.[42]

The PPACA requires that coverage for emergency services must be provided without prior authorization and regardless of whether the provider is a network provider. Services provided by non-network providers must be provided with cost-sharing that is no greater than that which would apply for a network provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. In addition, plans must reimburse non-network providers the greater of:

- The median in-network rate;
- The usual and customary reimbursement, calculated using the plan's formula; or
- The Medicare rate. [43]

Grandfathered health plans are exempt from these requirements.[44] PPACA does not prohibit balance billing. A guidance document from the U.S. Department of Labor has characterized the requirements as "set[ting] forth minimum payment standards...to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient." The guidance further states that the minimum payment requirements do not apply if state law prohibits balance billing or the plan is contractually responsible for payment.[45]

[39] s. 641.513(5), F.S.

[40] ss. 641.513(6) and 409.967(2)(b), F.S.

[41] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, H.R. 3590, 11th Cong. (March 23, 2010). On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.

[42] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act. (42 U.S.C. 300gg et seq.).

[43] 45 C.F.R. s. 147.138(b)

[44] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. Grandfathered health plan coverage is tied to the individual or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. (PPACA § 1251; 42 U.S.C. § 18011; 45 C.F.R. § 147.140).

[45] U.S. Dept. of Labor, Employee Benefits Security Administration, *FAQs About the Affordable Care Act Implementation Part I*, http://www.dol.gov/ebsa/faqs/faq-aca.html (last visited March 16, 2015).

Hospital Emergency Department Utilization by Payer Type

The following reflects utilization of hospital emergency departments by payer type during the 12-month period ending July 1, 2014.[46]

	ED Visits - Inpatient admission		ED Visits - No admission		Totals	
Medicare	600,583	36.1%	852,375	11.0%	1,452,958	15.4%
Medicare HMO	293,605	17.7%	474,522	6.1%	768127	8.2%
Medicaid	164,457	9.9%	1,327,002	17.1%	1491459	15.9%
Medicaid HMO	100,517	6.0%	1,222,919	15.8%	1323436	14.1%
Commercial	272,038	16.4%	1,749,662	22.6%	2021700	21.5%
Workers Compensation	4,382	0.3%	76,301	1.0%	80683	0.9%
TRICARE	13,296	0.8%	117,074	1.5%	130370	1.4%
VA	12,327	0.7%	25,683	0.3%	38010	0.4%
Other Government	13,433	0.8%	55,819	0.7%	69252	0.7%
Self-pay	136,086	8.2%	1,549,706	20.0%	1685792	17.9%
Other	4,519	0.3%	29,336	0.4%	33855	0.4%
Charity	38,213	2.3%	157,580	2.0%	195793	2.1%
KidCare	1,849	0.1%	40,330	0.5%	42179	0.4%
Commercial Liability	6,408	0.4%	66,152	0.9%	72560	0.8%
TOTALS	**1,661,713**		**7,744,461**		**9,406,174**	

Effect of Changes Related to Payment for Emergency Care and Treatment

The bill creates a new section of law that establishes requirements for PPOs and EPOs related to coverage for emergency care, including prehospital transport. Specifically, the bill:

- Prohibits prior authorization;
- Requires coverage whether service is provided by a participating (contract) or nonparticipating (noncontract) provider;
- Requires cost-sharing to be the same for network or non-network

The bill requires PPOs and EPOs to reimburse nonparticipating providers not more than the greater of:

- The rate negotiated with a participating provider;
- The usual and customary reimbursement, calculated using the plan's formula; or
- The Medicare rate.

The bill prohibits nonparticipating providers from balance billing.

The effect of the changes is to impose a payment methodology applicable to EPO and PPO reimbursement of emergency services provided by nonparticipating providers that parallels the standard imposed by PPACA. The bill differs from PPACA, however, in that PPACA does not prohibit balance billing and, by directive of the U.S. Department of Labor, does not impose the payment methodology in states that prohibit balance billing. The bill prohibits balance billing and prohibits a PPO or EPO from voluntarily reimbursing a nonparticipating provider an amount higher than what is provided in the bill. In effect, the bill establishes a cap for reimbursement.

[46] Inpatient and emergency department discharge data are reported to the AHCA by hospitals pursuant to s. 408.061(1(a), F.S. and are publicly-available. *See* AGENCY FOR HEALTH CARE ADMINISTRATION, *FloridaHealthFinder.gov*, http://www.floridahealthfinder.gov/researchers/researchers.aspx (last visited March 15, 2015).

The bill also revises the methodology for determining reimbursement applicable to commercial HMOs to conform to the new methodology applicable to PPOs and EPOs and makes similar changes to the Medicaid HMO reimbursement methodology. The effect is to change the reimbursement standard from one that is based on provider charges to one that is based on provider reimbursement.

B. SECTION DIRECTORY:

Section 1: Creates s. 627,64194, F.S., relating to coverage for emergency services.

Section 2: Amends s. 641.513, F.S., relating to requirements for providing emergency services and care.

Section 3: Provides an effective date of October 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The AHCA projects a negative but indeterminate fiscal impact as a result of the change to the payment methodology for emergency services and care rendered by noncontract providers to HMO members. The AHCA projects that the change will result in a higher reimbursement amount, but indicates that utilization and cost data required to perform an aggregate quantitative cost comparison are not currently available and will not be available unless and until the changes proposed in the bill are implemented. The AHCA bases its analysis on the change in the standard from a "lesser of" to a "greater of" standard.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Local governments participate in the Medicaid program through required cost sharing set forth in s. 409.915, F.S. The revisions to the payment methodology for emergency services and care provided by a noncontract provider to an HMO's member could affect the total dollar value of a county's contribution if it were significant enough to increase or decrease overall program costs.

   Those county and municipal governments currently providing ambulance services would experience a negative fiscal impact from the provisions that prohibit balance billing to the extent that those governments currently rely on that practice. This could result in a cost shift to local taxpayers who may be required to subsidize or further subsidize ambulance operations. In addition, affected counties and municipalities may see a fiscal impact as a result of the methodology for reimbursement. The actual impact will vary from county-to-county and city-to-city depending on the service and payment structure in place and how the services are funded, i.e. fee based, tax subsidized, etc.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private providers of emergency services and care, including ambulance service providers, would experience a negative fiscal impact from the provisions that prohibit balance billing to the extent that those providers currently rely on that practice. In addition, private providers may see a fiscal impact as a result of the methodology for reimbursement.

Consumers who receive coverage through a PPO or EPO will benefit from the provision that prohibits balance billing.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   The Supremacy Clause of the U.S. Constitution preempts state laws that impermissibly interfere with federal law.[47] Preemption can be express or implied. When Congress chooses to expressly preempt state law, the only question for courts becomes determining whether the challenged state law is one that the federal law is intended to preempt. Implied preemption occurs either as a result of field preemption or conflict preemption.[48] Federal law "occupies the field" when there is "no room" left for state regulation.[49] Conflict preemption occurs where "compliance with both federal and state regulations is a physical impossibility."[50]

   The Airline Deregulation Act of 1978 was enacted by Congress to encourage, develop, and attain an air transportation system which relies on competitive market forces to determine the quality, variety, and price of air services, among other purposes.[51] By its terms, the act preempts the authority of a state "to enact or enforce a law, regulation, or other provision having the force and effect of law related to a price, route, or service of an air carrier that may provide air transportation under this subpart."[52] HB 681 creates a new section of law that prohibits nonparticipating providers from balance billing a patient for emergency services and care, including transport by ambulance, emergency medical services vehicle, or air ambulance. It further establishes a payment methodology to be used in determining the amount of payment for covered services provided by noncontract providers. This does not itself establish a payment rate, but relates to rate setting. The bill covers services provided by a PPO or an EPO and would affect an air ambulance provider that is not contracted with a PPO or EPO, but providing services to its members. Thus, the application of the bill to air ambulance providers may be preempted by federal law.

3. RULE-MAKING AUTHORITY:

None.

---

[47] U.S. CONST. art. 5, cl. 2.
[48] Erwin Chemerinsky, CONSTITUTIONAL LAW, 367 (2d ed. 2005).
[49] *Pennsylvania vs Nelson*, 350 U.S. 497 (1956).
[50] *Florida Lime and Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963).
[51] Airline Deregulation Act of 1978, Pub. L. No. 95-504, S. 293, 95th Cong. (Oct. 24, 1978).
[52] 49 U.S.C.§ 4713(b)

4. DRAFTING ISSUES OR OTHER COMMENTS:

The bill revises s.641.513(6), F.S., related to the payment methodology for emergency services and care rendered by noncontract providers under the Medicaid program. It fails, however, to make conforming changes to s. 409.967(2)(b), F.S., and thus conflicts.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to health insurance coverage for
3 emergency services; creating s. 627.64194, F.S.;
4 defining terms; prohibiting coverage for emergency
5 services from requiring a prior authorization
6 determination; requiring such coverage to be provided
7 regardless of whether the service is furnished by a
8 participating or nonparticipating provider; specifying
9 coinsurance, copayment, limitation of benefits, and
10 reimbursement requirements for nonparticipating
11 providers; prohibiting a nonparticipating provider
12 from collecting or attempting to collect an amount in
13 excess of specified amounts; amending s. 641.513,
14 F.S.; revising the methodology for determining health
15 maintenance organization reimbursement amounts for
16 emergency services and care provided by certain
17 providers; providing an effective date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Section 627.64194, Florida Statutes, is created
22 to read:
23 627.64194 Coverage for emergency services.—
24 (1) As used in this section, the term:
25 (a) "Coverage for emergency services" means the coverage
26 provided by a health insurance policy for "emergency services

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

27 and care" as that term is defined in s. 641.47 or emergency
28 medical transportation services, which include transport by an
29 ambulance, emergency medical services vehicle, or air ambulance,
30 as those terms are defined in s. 401.23.
31 (b) "Participating provider" means a "preferred provider"
32 as defined in s. 627.6471 and an "exclusive provider" as defined
33 in s. 627.6472.
34 (2) Coverage for emergency services:
35 (a) May not require a prior authorization determination.
36 (b) Must be provided regardless of whether the service is
37 furnished by a participating or nonparticipating provider.
38 (c) May impose a coinsurance amount, copayment, or
39 limitation of benefits requirement for a nonparticipating
40 provider only if the same requirement applies to a participating
41 provider.
42 (d) Must reimburse a nonparticipating provider the greater
43 of the following:
44 1. The amount negotiated with a participating provider or
45 a nonparticipating provider for the service, excluding any
46 coinsurance amount or copayment imposed by a participating
47 provider on the participant, beneficiary, or enrollee.
48 2. The amount calculated under the methodology generally
49 used by the insurer to determine the reimbursement amount to a
50 nonparticipating provider for the service, such as the usual,
51 customary, and reasonable amount, reduced only by a coinsurance
52 amount or copayment that applies to a participating provider.

53 3. The amount that would be paid under Medicare for the
54 service, reduced only by a coinsurance amount or copayment that
55 applies to a participating provider.
56 (3) A nonparticipating provider may not be reimbursed an
57 amount greater than that provided under paragraph (2)(d) and may
58 not collect or attempt to collect, directly or indirectly, any
59 excess amount.
60 Section 2. Subsections (5) and (6) of section 641.513,
61 Florida Statutes, are amended to read:
62 641.513 Requirements for providing emergency services and
63 care.—
64 (5) Reimbursement for services pursuant to this section by
65 a provider who does not have a contract with the health
66 maintenance organization shall be the greater ~~lesser~~ of:
67 (a) The Medicare allowable rate ~~provider's charges~~;
68 (b) The amount calculated under the methodology generally
69 used by the health maintenance organization to determine the
70 reimbursement amount to a provider who does not have a contract
71 with the health maintenance organization for the service ~~usual~~
72 ~~and customary provider charges for similar services in the~~
73 ~~community where the services were provided~~; or
74 (c) The amount negotiated with a provider who does not
75 have a contract with the health maintenance organization for the
76 service ~~charge mutually agreed to by the health maintenance~~
77 ~~organization and the provider within 60 days of the submittal of~~
78 ~~the claim~~.

79

80 Such reimbursement shall be net of any applicable copayment
81 authorized pursuant to subsection (4).
82 (6) Reimbursement for services under this section provided
83 to subscribers who are Medicaid recipients by a provider for
84 whom no contract exists between the provider and the health
85 maintenance organization shall be the greater ~~lesser~~ of:
86 ~~(a) The provider's charges;~~
87 (a) ~~(b)~~ The amount calculated under the methodology
88 generally used by the health maintenance organization to
89 determine the reimbursement amount to a provider who does not
90 have a contract with the health maintenance organization for the
91 service ~~usual and customary provider charges for similar~~
92 ~~services in the community where the services were provided~~;
93 (b) ~~(c)~~ The amount negotiated with a provider who does not
94 have a contract with the health maintenance organization for the
95 service ~~charge mutually agreed to by the entity and the provider~~
96 ~~within 60 days after submittal of the claim~~; or
97 (c) ~~(d)~~ The Medicaid rate.
98 Section 3. This act shall take effect October 1, 2015.

Insurance & Banking Subcommittee

HB 681 by Rep. Trujillo
Health Insurance Coverage for Emergency Services

AMENDMENT SUMMARY
March 10, 2015

Amendment 1 by Rep. Trujillo (strike-all): Contains all of the provisions of the bill, except:

- Removes prehospital transportation service providers from the bill.
- Revises the reimbursement methodology for PPO and EPO providers by correcting language related to the negotiated rate and cost-sharing which references a participating provider.
- Revises the PPO and EPO provider and Medicaid and commercial HMO reimbursement methodologies to specify usual and customary reimbursement based on a community standard in lieu of the more general language used in the bill, and adds conforming language to chapter 409, related to Medicaid.

Amendment 1a to Amendment 1 by Rep. Plakon (line 55): Creates an additional reimbursement option for physicians who are PPO or EPO providers equal to the allowable changes under PIP.

Amendment 1b to Amendment 1 by Rep. Plakon (line 73): Creates an additional reimbursement option for physicians who are commercial HMO providers equal to the allowable changes under PIP.

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		

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Trujillo offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Paragraph (b) of subsection (2) of section
8 409.967, Florida Statutes, is amended to read:
9 409.967 Managed care plan accountability.—
10 (2) The agency shall establish such contract requirements
11 as are necessary for the operation of the statewide managed care
12 program. In addition to any other provisions the agency may deem
13 necessary, the contract must require:
14 (b) Emergency services.—Managed care plans shall pay for
15 services required by ss. 395.1041 and 401.45 and rendered by a
16 noncontracted provider. The plans must comply with s. 641.3155.

17 Reimbursement for services under this paragraph is the lesser
18 of:
19 ~~1. The provider's charges;~~
20 1.~~2.~~ The usual and customary reimbursement received by a
21 provider ~~charges~~ for the same service ~~similar services~~ in the
22 community where the service was ~~services were~~ provided;
23 2.~~3.~~ The amount negotiated with a provider who does not
24 have a contract with the health maintenance organization for the
25 service ~~charge mutually agreed to by the entity and the provider~~
26 ~~within 60 days after submittal of the claim~~; or
27 3.~~4.~~ The rate the agency would have paid on the most
28 recent October 1st.
29 Section 2. Section 627.64194, Florida Statutes, is created
30 to read:
31 627.64194 Coverage for emergency services.—
32 (1) As used in this section, the term:
33 (a) "Coverage for emergency services" means the coverage
34 provided by a health insurance policy for "emergency services
35 and care" as defined in s. 641.47.
36 (b) "Participating provider" means a "preferred provider"
37 as defined in s. 627.6471 and an "exclusive provider" as defined
38 in s. 627.6472.
39 (2) Coverage for emergency services:
40 (a) May not require a prior authorization determination.
41 (b) Must be provided regardless of whether the service is
42 furnished by a participating or nonparticipating provider.

43 (c) May impose a coinsurance amount, copayment, or
44 limitation of benefits requirement for a nonparticipating
45 provider only if the same requirement applies to a participating
46 provider.
47 (d) Must reimburse a nonparticipating provider the greater
48 of the following:
49 1. The amount negotiated with a provider who does not have
50 a contract with the insurer for the service, reduced only by any
51 coinsurance amount or copayment that applies to the provider;
52 2. The usual and customary reimbursement received by a
53 provider for the same service in the community where the service
54 was provided, reduced only by any coinsurance amount or
55 copayment that applies to the provider; or
56 3. The amount that would be paid under Medicare for the
57 service, reduced only by any coinsurance amount or copayment
58 that applies to the provider.
59 (3) A nonparticipating provider may not be reimbursed an
60 amount greater than that provided under paragraph (2)(d) and may
61 not collect or attempt to collect, directly or indirectly, any
62 excess amount.
63 Section 3. Subsections (5) and (6) of section 641.513,
64 Florida Statutes, are amended to read:
65 641.513 Requirements for providing emergency services and
66 care.—

67 (5) Reimbursement for services pursuant to this section by
68 a provider who does not have a contract with the health
69 maintenance organization shall be the greater ~~lesser~~ of:
70 (a) The Medicare allowable rate ~~provider's charges~~;
71 (b) The usual and customary reimbursement received by a
72 provider ~~charges~~ for the same service ~~similar services~~ in the
73 community where the service was ~~services were~~ provided; or
74 (c) The amount negotiated with a provider who does not
75 have a contract with the health maintenance organization for the
76 service ~~charge mutually agreed to by the health maintenance~~
77 ~~organization and the provider within 60 days of the submittal of~~
78 ~~the claim~~.
79
80 Such reimbursement shall be net of any applicable copayment
81 authorized pursuant to subsection (4).
82 (6) Reimbursement for services under this section provided
83 to subscribers who are Medicaid recipients by a provider for
84 whom no contract exists between the provider and the health
85 maintenance organization shall be the greater ~~lesser~~ of:
86 ~~(a) The provider's charges;~~
87 (a) ~~(b)~~ The usual and customary reimbursement received by a
88 provider ~~charges~~ for the same service ~~similar services~~ in the
89 community where the service was ~~services were~~ provided;
90 (b) ~~(c)~~ The amount negotiated with a provider who does not
91 have a contract with the health maintenance organization for the

92 service ~~charge mutually agreed to by the entity and the provider~~
93 ~~within 60 days after submittal of the claim~~; or
94 (c) ~~(d)~~ The Medicaid rate.
95 Section 4. This act shall take effect October 1, 2015.
96
97 ---
98 **T I T L E A M E N D M E N T**
99 Remove everything before the enacting clause and insert:
100 A bill to be entitled
101 An act relating to health insurance coverage for
102 emergency services; amending s.409.967, F.S.; revising
103 the methodology for determining health maintenance
104 organization reimbursement amounts for emergency
105 services and care provided by certain Medicaid
106 providers; creating s. 627.64194, F.S.; defining
107 terms; prohibiting coverage for emergency services
108 from requiring a prior authorization determination;
109 requiring such coverage to be provided regardless of
110 whether the service is furnished by a participating or
111 nonparticipating provider; specifying coinsurance,
112 copayment, limitation of benefits, and reimbursement
113 requirements for nonparticipating providers;
114 prohibiting a nonparticipating provider from
115 collecting or attempting to collect an amount in
116 excess of specified amounts; amending s. 641.513,
117 F.S.; revising the methodology for determining health

118 maintenance organization reimbursement amounts for
119 emergency services and care provided by certain
120 providers; providing an effective date.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 681 (2015)

Amendment No. a1

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	___	

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Plakon offered the following:
4
5 **Amendment to Amendment (188043) by Representative Trujillo**
6 Remove lines 55-58 of the amendment and insert:
7 copayment that applies to the provider;
8 3. The amount that would be paid under Medicare for the
9 service, reduced only by any coinsurance amount or copayment
10 that applies to the provider; or
11 4. For services provided by physicians licensed under
12 chapter 458 or 459, the charges allowed pursuant to s.
13 627.736(5)(a).

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 681 (2015)

Amendment No. a2

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	______	

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Plakon offered the following:
4
5 **Amendment to Amendment (188043) by Representative Trujillo**
6 Remove lines 73-78 of the amendment and insert:
7 community where the service was ~~services were~~ provided;
8 (c) The amount negotiated with a provider who does not have
9 a contract with the health maintenance organization for the
10 service ~~charge mutually agreed to by the health maintenance~~
11 ~~organization and the provider within 60 days of the submittal of~~
12 ~~the claim~~; or
13 (d) For services provided by physicians licensed under
14 chapter 458 or 459, the charges allowed for s. 627.736(5)(a)

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 731 Employee Health Care Plans
SPONSOR(S): Health Innovation Subcommittee; Plakon
TIED BILLS: **IDEN./SIM. BILLS:** SB 968

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 0 N, As CS	Tuszynski	Poche
2) Insurance & Banking Subcommittee		Haston SH	Cooper TRC
3) Government Operations Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

The Employee Health Care Access Act (EHCAA) was enacted in Florida in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status. The EHCAA requires health insurers and health maintenance organizations (carriers) in the small group market to offer coverage to all small employers, including sole proprietors, on a guaranteed-issue basis. Carriers are required to offer a standard benefit plan, a basic health benefit plan, and a high deductible plan, which meets the requirements of health savings account plans, to any small employer who applies for coverage, regardless of the health status of the employees. The EHCAA establishes limitations on exclusions and mandates various other enrollment and reporting requirements to foster fairness and efficiency in the small group health insurance market.

The Patient Protection and Affordable Care Act (PPACA) made many fundamental changes to the health insurance industry by imposing extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, required review of rate increases, and other requirements. Many of the changes outlined in the PPACA apply to individual and small group markets. For example, the PPACA requires coverage offered in the individual and small group markets to provide defined essential health benefits packages and limits rate adjustment based on certain factors, while prohibiting adjustments based on other factors.

HB 731 amends the EHCAA, removing the following provisions which are out of date or conflict with federal law:

- The requirement that a carrier offer standard, basic, and high deductible plans to a small employer. Federal law requires all small group health plans to include essential health benefits, which are not included in these plans.
- The requirement for an annual August open enrollment period for sole proprietors. Federal law now requires small employer carriers to have continuous open enrollment.
- The requirement for small employer carriers to submit a semiannual report to the Office of Insurance Regulation concerning the use of rating factors to adjust premiums in the small group market.
- A provision that indexes reinsurance premium rates to approximate gross premium rates of standard and basic health plans.
- A provision that requires the development of standards for agent compensation for the sale of basic and standard health plans.
- The requirement for the Chief Financial Officer to appoint the health benefit plan committee, as well as the duties of that committee to make recommendations concerning basic and standard health plans.

The bill defines "stop-loss insurance policy" and exempts such policies from the EHCAA.

The bill requires that a stop-loss insurance policy be subject to the EHCAA if the policy has an aggregate attachment point that is lower than the greatest of:

- $2,000 multiplied by the number of employees;
- 120 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill requires the stop-loss insurance policy to cover 100 percent of all claims equal to or above the attachment point.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Employee Heath Care Access Act

The Employee Health Care Access Act (EHCAA)[1] was enacted in Florida in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status.[2] The EHCAA requires health insurers and health maintenance organizations (carriers) in the small group market to offer coverage to all small employers, including sole proprietors, on a guaranteed-issue basis. For sole proprietors, the offer of coverage may be limited to a one-month open enrollment period in August.[3]

Carriers are required to offer a standard benefit plan, a basic health benefit plan, and a high deductible plan, which meets the requirements of health savings account plans, to any small employer who applies for coverage, regardless of the health status of the employees.[4] A small employer carrier that offers coverage to a small employer must offer to all of the employer's eligible employees and their dependents.[5] The EHCAA establishes limitations on exclusions and mandates various other enrollment and reporting requirements to foster fairness and efficiency in the small group health insurance market.[6]

The EHCAA also created the Florida Small Employer Carrier Reinsurance Program (Program). The Program, now operating as the Florida Health Insurance Advisory Board (Board),[7] recommends to the Office of Insurance Regulation (OIR), among other things, market conduct and other requirements for agents and carriers selling and writing policies in the small group market, including:

- The registration by each carrier of its intention to be a small employer carrier;
- The publication of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;
- The availability of a toll-free telephone number for access by small employers to information concerning the Program;
- Periodic reports by carriers and agents concerning health benefit plans issued; and
- Methods for small employer carriers and agents to demonstrate that they are marketing or issuing health benefit plans to small employers.[8]

The EHCAA mandates that the Chief Financial Officer (CFO) appoint a health benefit plan committee (Committee) to submit recommendations to the board in relation to standard, basic, high deductible, and limited plans.[9] In 2002, following double digit rate increases for small employers, a lag in the offering of small group coverage, and a failure to update plan benefits since the early 1990s, the Committee recommended comprehensive revisions to the standard and basic plans to include more

[1] s. 627.6699, F.S.
[2] Ch. 92-33, Laws of Fla.
[3] s. 627.6699(5)(c)2., F.S.
[4] s. 627.6699(12)(b)1., F.S.
[5] s. 627.6699(5)(h)5., F.S.
[6] s. 627.6699, F.S.
[7] The Board's responsibilities were expanded in 2005 to include an advisory role on health insurance issues to OIR, the Agency for Health Care Administration, the Department of Financial Services, executive departments and the Legislature. *See* s. 627.6699(11)(o), F.S.
[8] ss. 627.6699(11)(e)1. – 5., F.S.
[9] s. 627.6699(12)(a)1., F.S.

robust benefits that mirrored those benefits offered in plans on the market at the time.[10] The recommendations were adopted by the CFO for all small group plan coverage effective April 1, 2003.[11] It appears that the 2002 report may have been the last work of this Committee.

Under the EHCAA, each carrier is required to submit a semiannual report that shows the effects of certain rating factors in setting premiums.[12] The report allows OIR to compare the actual adjusted aggregate premiums charged to policyholders by each carrier to the premiums that would have been charged if the carrier's approved modified community rates were applied.[13] A modified community rate allows a carrier to spread financial risk across a large population using separate rating factors such as age, gender, family composition, and tobacco usage.[14] It also permits adjustments to the rate for claims experience, health status, and certain expenses incurred by the carrier.[15] If the aggregate premium actually charged exceeds the premium that would have been charged by applying the modified community rate by 4 percent or more, the carrier is limited in the application of rate adjustments.[16]

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA)[17] made many fundamental changes to the health insurance industry by imposing extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, required review of rate increases, and other requirements.[18] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors.

Many of the changes outlined in the PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[19] For example, the PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):[20]

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

---

[10] Florida Small Employer Benefits Plan Committee, Nov. 2002, *available at* www.floir.com/siteDocuments/Sm_Emp_Grp_Benefit_Comm_Rpt_%20Nov02.pdf
[11] Florida Department of Financial Services, *Informational Memorandum DFS-03-001M*, Mar. 6, 2003, *available at* www.floir.com/siteDocuments/dfs-03-001m.pdf.
[12] s. 627.6699(6)(b)(5), F.S.
[13] *Id.*
[14] s. 627.6699(3)(o), F.S.
[15] *Id.*
[16] s. 627.6699(6)(b)(5), F.S.
[17] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148.
[18] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), 42 U.S.C. § 300gg et seq.
[19] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. *See* PPACA s. 1251; 42 U.S.C. § 18011.
[20] PPACA s. 1302; 42 U.S.C. § 300gg-6.

Also, the PPACA requires that premiums for individual and small group policies may vary only by:[21]

- Age, up to a maximum ratio of 3 to 1. This means that the rates for older adults cannot be more than three times greater than the rates for younger adults.
- Tobacco, up to a maximum ratio of 1.5 to 1.
- Geographic rating area.
- Whether coverage is for an individual or a family.

The PPACA prohibits an insurer from establishing rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or any other health-status related factor deemed appropriate by the U.S. Department of Health and Human Services.[22]

Small employer carriers are required, under the PPACA, to have continuous open enrollment.[23]

<u>Stop-Loss Insurance Coverage</u>

Florida law defines stop-loss insurance as an arrangement in which an insurer insures a policyholder against the risk that any one claim will exceed a specified dollar amount or that an entire self-insurance plan's loss will exceed a specified amount.[24] Stop-loss insurance is more fully defined in Rule 69O-149.0025(23), F.A.C., as coverage purchased by an entity, generally an employer, for the purpose of covering the entity's obligation for the excess cost of medical care provided under a self-insured health benefit plan. Such insurance coverage takes effect once a claim cost or total plan loss reaches a certain amount, known as the attachment point. Small employers who are self-insured for health care coverage of their employees purchase stop-loss insurance to limit their financial risk in the case of catastrophic medical costs incurred by their employees.

Rule 69O-149.0025(23), F.A.C., establishes standards to distinguish a small group health insurance policy, which is subject to the provisions of the EHCAA, from a stop-loss insurance policy, which is exempt from the provisions of the EHCAA. Such coverage is considered as a health insurance policy, rather than as a stop-loss insurance policy, if it:

- Has an attachment point for claims incurred per individual which is lower than $20,000; or
- For insured employer groups with fifty or fewer covered employees, has an aggregate attachment point which is lower than the greater of:
  - $4,000 times the number of employees;
  - 120 percent of expected claims; or
  - $20,000; or
- For insured employer groups with fifty-one or more covered employees, has an aggregate attachment point which is lower than 110 percent of expected claims.[25]

Insurers are required to determine the number of covered employees of an employer, for purposes of applying the appropriate attachment point, on a consistent basis. An insurer can base it's determination of the number of employees employed on an annual basis or at a specific time.[26]

---

[21] PPACA s. 1201; 42 U.S.C. § 300gg.
[22] PPACA s. 1201; 42 U.S.C. § 300gg-4.
[23] 45 C.F.R. § 147.104.
[24] s. 627.6482(14), F.S.
[25] Rule 69O-149.0025(23), F.A.C.
[26] Rule 69O-149.0025(23)(b)3., F.A.C.

Effect of Proposed Changes

HB 731 deletes s. 627.6699(12), F.S., which removes the requirement that a carrier offer standard, basic, and high deductible plans to a small employer. Federal law requires all small group health plans, except those plans with grandfather status, to include essential health benefits. The plans required to be offered to small group employers in s. 627.6699(12), F.S., do not include essential health benefits and cannot be sold in Florida. However, because the requirement remains in statute, insurers are required to submit plan forms to OIR, which are then rejected. By removing the requirement, insurers will not be required to submit the plan forms to OIR for review, and OIR will not be required to review the forms. The bill also removes the requirement that a small group carrier submit information regarding standard and basic plans on a quarterly basis to the OIR.

The bill removes the requirement for an annual August open enrollment period for sole proprietors. Federal law now requires small employer carriers to have continuous open enrollment, which supersedes the annual open enrollment period in statute.

The bill also removes the requirement for small employer carriers to submit a semiannual report to OIR with information related to actual aggregate premiums charged to policyholders and the aggregate premiums that would have been charged using the carrier's approved modified community rating, which is based on certain factors in statute. Federal law allows premiums for individual and small group policies to be adjusted using a much narrower group of factors. Because carriers adjust rates using the same limited factors set out in federal law, the semiannual report no longer includes useful information.

The bill deletes language that bases reinsurance premium rates on the approximate gross premium rates of standard and basic health plans. Standard and basic health plans can no longer be offered or sold under federal law because such plans do not include essential health benefits. As a result, keying reinsurance premium rates to rates of plans that are not offered or sold is moot. While no other basis for these rates is provided, any rate set by the board is subject to the approval of OIR.

The bill deletes language that requires the board to develop standards for compensation of agents for the sale of basic and standard health plans. As those plans do not include essential health benefits and cannot be sold in Florida, these compensation standards are unnecessary.

The bill also removes the requirement for the CFO to appoint the health benefit plan committee, as well as the duties of that committee to make recommendations concerning basic and standard health plans. Federal law removes the ability to sell standard, basic, high deductible and limited plans, so recommendations by the committee as to those plans are unnecessary. Furthermore, it does not seem that the Committee has made any recommendations to the board since 2002.

The bill defines "stop-loss insurance policy" and exempts such policies from the EHCAA.

The bill requires that a stop-loss insurance policy be subject to the EHCAA if the policy has an aggregate attachment point that is lower than the greatest of:

- $2,000 multiplied by the number of employees;
- 120 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill requires any stop-loss insurance policy authorized under the bill to cover 100 percent of all claims equal to or above the attachment point.

The bill also requires a carrier to use a uniform methodology for determining the number of employees to calculate the attachment point. The bill permits the methodology to be based on the number of employees employed on an annual basis or at a specific point in time during the year.

The bill also corrects cross-references and makes other conforming changes.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.
Section 2: Creates s. 627.66997, F.S., relating to stop-loss insurance.
Section 3: Amends s. 627.642, F.S., relating to outline of coverage.
Section 4: Amends s. 627.6475, F.S., relating to individual reinsurance pool.
Section 5: Amends s. 627.657, F.S., relating to provisions of group health insurance policies.
Section 6: Amends s. 627.6571, F.S., relating to guaranteed renewability of coverage.
Section 7: Amends s. 627.6675, F.S., relating to conversion on termination.
Section 8: Amends s. 641.31074, F.S., relating to guaranteed renewability.
Section 9: Amends s. 641.3922, F.S., relating to conversion contracts.
Section 10: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill deletes the requirement that a small group carrier offer standard and basic health benefit plan and high deductible plan to each small employer, upon request. The carrier may realize a decreased administrative burden in creating these plans and forms and submitting them to OIR. OIR may realize a decrease in workload as a result of no longer requiring the submission of the plan forms. The bill removes multiple reporting requirements, which may lower the administrative burden on carriers and decrease the workload of OIR in creating and reviewing of these reports.

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

On March 3, 2015, the Health Innovation Subcommittee adopted one amendment and reported the bill favorable as a committee substitute. The amendment made the following changes:

- Adds a definition of “stop-loss insurance policy”.
- Requires the calculation of expected claims, as a basis for determining the stop-loss policy attachment point, to be in accordance with actuarial standards of practice.
- Increases the dollar amount, as a basis for determining the stop-loss policy attachment point, to twenty thousand dollars.
- Requires a stop-loss insurance policy to cover 100 percent of all claims equal to or greater than the attachment point.
- Makes a technical change in language from “providers” to “carriers”.

The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.

1 A bill to be entitled
2 An act relating to employee health care plans;
3 amending s. 627.6699, F.S.; revising definitions;
4 removing provisions requiring certain insurance
5 carriers to provide semiannual reports to the Office
6 of Insurance Regulation; repealing requirements that
7 certain insurance carriers offer standard, basic, high
8 deductible, and limited health benefit plans; making
9 conforming changes; creating s. 627.66997, F.S.;
10 authorizing certain small employer health benefit
11 plans to use a stop-loss insurance policy; defining
12 the term "stop-loss insurance policy"; providing
13 requirements for such policies; amending ss. 627.642,
14 627.6475, and 627.657, F.S.; conforming cross-
15 references; amending ss. 627.6571, 627.6675,
16 641.31074, and 641.3922, F.S.; conforming provisions
17 to changes made by the act; providing an effective
18 date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Subsection (2) of section 627.6699, Florida
23 Statutes, is amended, paragraphs (c) through (x) of subsection
24 (3) are redesignated as paragraphs (b) through (w),
25 respectively, and present paragraphs (b) and (o) of that
26 subsection, subsection (5), paragraph (b) of subsection (6),

27 paragraphs (g), (h), (j), and (l) through (o) of subsection
28 (11), subsections (12) through (14), paragraph (k) of subsection
29 (15), and subsections (16) through (18) of that section are
30 amended, to read:
31 627.6699 Employee Health Care Access Act.—
32 (2) PURPOSE AND INTENT.—The purpose and intent of this
33 section is to promote the availability of health insurance
34 coverage to small employers regardless of their claims
35 experience or their employees' health status, to establish rules
36 regarding renewability of that coverage, to establish
37 limitations on the use of exclusions for preexisting conditions~~,~~
38 ~~to provide for development of a standard health benefit plan and~~
39 ~~a basic health benefit plan to be offered to all small~~
40 ~~employers~~, to provide for establishment of a reinsurance program
41 for coverage of small employers, and to improve the overall
42 fairness and efficiency of the small group health insurance
43 market.
44 (3) DEFINITIONS.—As used in this section, the term:
45 ~~(b) "Basic health benefit plan" and "standard health~~
46 ~~benefit plan" mean low-cost health care plans developed pursuant~~
47 ~~to subsection (12).~~
48 (n) ~~(o)~~ "Modified community rating" means a method used to
49 develop carrier premiums which spreads financial risk across a
50 large population; allows the use of separate rating factors for
51 age, gender, family composition, tobacco usage, and geographic
52 area as determined under paragraph (5)(f) ~~(5)(j)~~; and allows

53 adjustments for: claims experience, health status, or duration
54 of coverage as permitted under subparagraph (6)(b)5.; and
55 administrative and acquisition expenses as permitted under
56 subparagraph (6)(b)5.
57 (5) AVAILABILITY OF COVERAGE.—
58 ~~(a) Beginning January 1, 1993, every small employer~~
59 ~~carrier issuing new health benefit plans to small employers in~~
60 ~~this state must, as a condition of transacting business in this~~
61 ~~state, offer to eligible small employers a standard health~~
62 ~~benefit plan and a basic health benefit plan. Such a small~~
63 ~~employer carrier shall issue a standard health benefit plan or a~~
64 ~~basic health benefit plan to every eligible small employer that~~
65 ~~elects to be covered under such plan, agrees to make the~~
66 ~~required premium payments under such plan, and to satisfy the~~
67 ~~other provisions of the plan.~~
68 (a)~~(b) In the case of~~ A small employer carrier that ~~which~~
69 does not~~, on or after January 1, 1993,~~ offer coverage but renews
70 or continues ~~which does, on or after January 1, 1993, renew or~~
71 ~~continue~~ coverage in force must~~, such carrier shall be required~~
72 ~~to~~ provide coverage to newly eligible employees and dependents
73 on the same basis as small employer carriers that offer ~~which~~
74 ~~are offering~~ coverage ~~on or after January 1, 1993~~.
75 (b)~~(c)~~ Every small employer carrier must, as a condition
76 of transacting business in this state,~~:~~
77 ~~1.~~ offer and issue all small employer health benefit plans
78 on a guaranteed-issue basis to every eligible small employer,

79 with 2 to 50 eligible employees, that elects to be covered under
80 such plan, agrees to make the required premium payments, and
81 satisfies the other provisions of the plan. A rider for
82 additional or increased benefits may be medically underwritten
83 and may only be added to the standard health benefit plan. The
84 increased rate charged for the additional or increased benefit
85 must be rated in accordance with this section.
86 ~~2. In the absence of enrollment availability in the~~
87 ~~Florida Health Insurance Plan, offer and issue basic and~~
88 ~~standard small employer health benefit plans and a high-~~
89 ~~deductible plan that meets the requirements of a health savings~~
90 ~~account plan or health reimbursement account as defined by~~
91 ~~federal law, on a guaranteed-issue basis, during a 31-day open~~
92 ~~enrollment period of August 1 through August 31 of each year, to~~
93 ~~every eligible small employer, with fewer than two eligible~~
94 ~~employees, which small employer is not formed primarily for the~~
95 ~~purpose of buying health insurance and which elects to be~~
96 ~~covered under such plan, agrees to make the required premium~~
97 ~~payments, and satisfies the other provisions of the plan.~~
98 ~~Coverage provided under this subparagraph shall begin on October~~
99 ~~1 of the same year as the date of enrollment, unless the small~~
100 ~~employer carrier and the small employer agree to a different~~
101 ~~date. A rider for additional or increased benefits may be~~
102 ~~medically underwritten and may only be added to the standard~~
103 ~~health benefit plan. The increased rate charged for the~~
104 ~~additional or increased benefit must be rated in accordance with~~

105 ~~this section. For purposes of this subparagraph, a person, his~~
106 ~~or her spouse, and his or her dependent children constitute a~~
107 ~~single eligible employee if that person and spouse are employed~~
108 ~~by the same small employer and either that person or his or her~~
109 ~~spouse has a normal work week of less than 25 hours. Any right~~
110 ~~to an open enrollment of health benefit coverage for groups of~~
111 ~~fewer than two employees, pursuant to this section, shall remain~~
112 ~~in full force and effect in the absence of the availability of~~
113 ~~new enrollment into the Florida Health Insurance Plan.~~
114 ~~3. This paragraph does not limit a carrier's ability to~~
115 ~~offer other health benefit plans to small employers if the~~
116 ~~standard and basic health benefit plans are offered and~~
117 ~~rejected.~~
118 ~~(d) A small employer carrier must file with the office, in~~
119 ~~a format and manner prescribed by the committee, a standard~~
120 ~~health care plan, a high deductible plan that meets the federal~~
121 ~~requirements of a health savings account plan or a health~~
122 ~~reimbursement arrangement, and a basic health care plan to be~~
123 ~~used by the carrier. The provisions of this section requiring~~
124 ~~the filing of a high deductible plan are effective September 1,~~
125 ~~2004.~~
126 ~~(e) The office at any time may, after providing notice and~~
127 ~~an opportunity for a hearing, disapprove the continued use by~~
128 ~~the small employer carrier of the standard or basic health~~
129 ~~benefit plan on the grounds that such plan does not meet the~~
130 ~~requirements of this section.~~

131 (c)~~(f)~~ Except as provided in paragraph (d) ~~(g)~~, a health
132 benefit plan covering small employers must comply with
133 preexisting condition provisions specified in s. 627.6561 or,
134 for health maintenance contracts, in s. 641.31071.
135 (d)~~(g)~~ A health benefit plan covering small employers,
136 issued or renewed on or after January 1, 1994, must comply with
137 the following conditions:
138 1. All health benefit plans must be offered and issued on
139 a guaranteed-issue basis~~, except that benefits purchased through~~
140 ~~riders as provided in paragraph (c) may be medically~~
141 ~~underwritten for the group, but may not be individually~~
142 ~~underwritten as to the employees or the dependents of such~~
143 ~~employees~~. Additional or increased benefits may only be offered
144 by riders.
145 2. ~~The provisions of~~ Paragraph (c) applies ~~(f) apply~~ to
146 health benefit plans issued to a small employer who has two or
147 more eligible employees~~,~~ and to health benefit plans that are
148 issued to a small employer who has fewer than two eligible
149 employees and that cover an employee who has had creditable
150 coverage continually to a date not more than 63 days before the
151 effective date of the new coverage.
152 3. For health benefit plans that are issued to a small
153 employer who has fewer than two employees and that cover an
154 employee who has not been continually covered by creditable
155 coverage within 63 days before the effective date of the new
156 coverage, preexisting condition provisions must not exclude

157 coverage for a period beyond 24 months following the employee's
158 effective date of coverage and may relate only to:
159 a. Conditions that, during the 24-month period immediately
160 preceding the effective date of coverage, had manifested
161 themselves in such a manner as would cause an ordinarily prudent
162 person to seek medical advice, diagnosis, care, or treatment or
163 for which medical advice, diagnosis, care, or treatment was
164 recommended or received; or
165 b. A pregnancy existing on the effective date of coverage.
166 (e) ~~(h)~~ All health benefit plans issued under this section
167 must comply with the following conditions:
168 1. For employers who have fewer than two employees, a late
169 enrollee may be excluded from coverage for no longer than 24
170 months if he or she was not covered by creditable coverage
171 continually to a date not more than 63 days before the effective
172 date of his or her new coverage.
173 2. Any requirement used by a small employer carrier in
174 determining whether to provide coverage to a small employer
175 group, including requirements for minimum participation of
176 eligible employees and minimum employer contributions, must be
177 applied uniformly among all small employer groups having the
178 same number of eligible employees applying for coverage or
179 receiving coverage from the small employer carrier, except that
180 a small employer carrier that participates in, administers, or
181 issues health benefits pursuant to s. 381.0406 which do not
182 include a preexisting condition exclusion may require as a

183 condition of offering such benefits that the employer has had no
184 health insurance coverage for its employees for a period of at
185 least 6 months. A small employer carrier may vary application of
186 minimum participation requirements and minimum employer
187 contribution requirements only by the size of the small employer
188 group.
189 3. In applying minimum participation requirements with
190 respect to a small employer, a small employer carrier shall not
191 consider as an eligible employee employees or dependents who
192 have qualifying existing coverage in an employer-based group
193 insurance plan or an ERISA qualified self-insurance plan in
194 determining whether the applicable percentage of participation
195 is met. However, a small employer carrier may count eligible
196 employees and dependents who have coverage under another health
197 plan that is sponsored by that employer.
198 4. A small employer carrier shall not increase any
199 requirement for minimum employee participation or any
200 requirement for minimum employer contribution applicable to a
201 small employer at any time after the small employer has been
202 accepted for coverage, unless the employer size has changed, in
203 which case the small employer carrier may apply the requirements
204 that are applicable to the new group size.
205 5. If a small employer carrier offers coverage to a small
206 employer, it must offer coverage to all the small employer's
207 eligible employees and their dependents. A small employer
208 carrier may not offer coverage limited to certain persons in a

209 group or to part of a group, except with respect to late
210 enrollees.
211 6. A small employer carrier may not modify any health
212 benefit plan issued to a small employer with respect to a small
213 employer or any eligible employee or dependent through riders,
214 endorsements, or otherwise to restrict or exclude coverage for
215 certain diseases or medical conditions otherwise covered by the
216 health benefit plan.
217 7. An initial enrollment period of at least 30 days must
218 be provided. An annual 30-day open enrollment period must be
219 offered to each small employer's eligible employees and their
220 dependents. A small employer carrier must provide special
221 enrollment periods as required by s. 627.65615.
222 ~~(i)1. A small employer carrier need not offer coverage or~~
223 ~~accept applications pursuant to paragraph (a):~~
224 ~~a. To a small employer if the small employer is not~~
225 ~~physically located in an established geographic service area of~~
226 ~~the small employer carrier, provided such geographic service~~
227 ~~area shall not be less than a county;~~
228 ~~b. To an employee if the employee does not work or reside~~
229 ~~within an established geographic service area of the small~~
230 ~~employer carrier; or~~
231 ~~c. To a small employer group within an area in which the~~
232 ~~small employer carrier reasonably anticipates, and demonstrates~~
233 ~~to the satisfaction of the office, that it cannot, within its~~
234 ~~network of providers, deliver service adequately to the members~~

235 ~~of such groups because of obligations to existing group contract~~
236 ~~holders and enrollees.~~
237 ~~2. A small employer carrier that cannot offer coverage~~
238 ~~pursuant to sub-subparagraph 1.c. may not offer coverage in the~~
239 ~~applicable area to new cases of employer groups having more than~~
240 ~~50 eligible employees or small employer groups until the later~~
241 ~~of 180 days following each such refusal or the date on which the~~
242 ~~carrier notifies the office that it has regained its ability to~~
243 ~~deliver services to small employer groups.~~
244 ~~3.a. A small employer carrier may deny health insurance~~
245 ~~coverage in the small-group market if the carrier has~~
246 ~~demonstrated to the office that:~~
247 ~~(I) It does not have the financial reserves necessary to~~
248 ~~underwrite additional coverage; and~~
249 ~~(II) It is applying this sub-subparagraph uniformly to all~~
250 ~~employers in the small-group market in this state consistent~~
251 ~~with this section and without regard to the claims experience of~~
252 ~~those employers and their employees and their dependents or any~~
253 ~~health-status-related factor that relates to such employees and~~
254 ~~dependents.~~
255 ~~b. A small employer carrier, upon denying health insurance~~
256 ~~coverage in connection with health benefit plans in accordance~~
257 ~~with sub-subparagraph a., may not offer coverage in connection~~
258 ~~with group health benefit plans in the small-group market in~~
259 ~~this state for a period of 180 days after the date such coverage~~
260 ~~is denied or until the insurer has demonstrated to the office~~

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

261 ~~that the insurer has sufficient financial reserves to underwrite~~
262 ~~additional coverage, whichever is later. The office may provide~~
263 ~~for the application of this sub-subparagraph on a service-area-~~
264 ~~specific basis.~~
265 ~~4. The commission shall, by rule, require each small~~
266 ~~employer carrier to report, on or before March 1 of each year,~~
267 ~~its gross annual premiums for all health benefit plans issued to~~
268 ~~small employers during the previous calendar year, and also to~~
269 ~~report its gross annual premiums for new, but not renewal,~~
270 ~~standard and basic health benefit plans subject to this section~~
271 ~~issued during the previous calendar year. No later than May 1 of~~
272 ~~each year, the office shall calculate each carrier's percentage~~
273 ~~of all small employer group health premiums for the previous~~
274 ~~calendar year and shall calculate the aggregate gross annual~~
275 ~~premiums for new, but not renewal, standard and basic health~~
276 ~~benefit plans for the previous calendar year.~~
277 (f)~~(j)~~ The boundaries of geographic areas used by a small
278 employer carrier must coincide with county lines. A carrier may
279 not apply different geographic rating factors to the rates of
280 small employers located within the same county.
281 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—
282 (b) For all small employer health benefit plans that are
283 subject to this section and issued by small employer carriers on
284 or after January 1, 1994, premium rates for health benefit plans
285 are subject to the following:
286 1. Small employer carriers must use a modified community

287 rating methodology in which the premium for each small employer
288 is determined solely on the basis of the eligible employee's and
289 eligible dependent's gender, age, family composition, tobacco
290 use, or geographic area as determined under paragraph (5)(f)
291 ~~(5)(j)~~ and in which the premium may be adjusted as permitted by
292 this paragraph. A small employer carrier is not required to use
293 gender as a rating factor for a nongrandfathered health plan.
294 2. Rating factors related to age, gender, family
295 composition, tobacco use, or geographic location may be
296 developed by each carrier to reflect the carrier's experience.
297 The factors used by carriers are subject to office review and
298 approval.
299 3. Small employer carriers may not modify the rate for a
300 small employer for 12 months from the initial issue date or
301 renewal date, unless the composition of the group changes or
302 benefits are changed. However, a small employer carrier may
303 modify the rate one time within the 12 months after the initial
304 issue date for a small employer who enrolls under a previously
305 issued group policy that has a common anniversary date for all
306 employers covered under the policy if:
307 a. The carrier discloses to the employer in a clear and
308 conspicuous manner the date of the first renewal and the fact
309 that the premium may increase on or after that date.
310 b. The insurer demonstrates to the office that
311 efficiencies in administration are achieved and reflected in the
312 rates charged to small employers covered under the policy.

313 4. A carrier may issue a group health insurance policy to
314 a small employer health alliance or other group association with
315 rates that reflect a premium credit for expense savings
316 attributable to administrative activities being performed by the
317 alliance or group association if such expense savings are
318 specifically documented in the insurer's rate filing and are
319 approved by the office. Any such credit may not be based on
320 different morbidity assumptions or on any other factor related
321 to the health status or claims experience of any person covered
322 under the policy. This subparagraph does not exempt an alliance
323 or group association from licensure for activities that require
324 licensure under the insurance code. A carrier issuing a group
325 health insurance policy to a small employer health alliance or
326 other group association shall allow any properly licensed and
327 appointed agent of that carrier to market and sell the small
328 employer health alliance or other group association policy. Such
329 agent shall be paid the usual and customary commission paid to
330 any agent selling the policy.
331 5. Any adjustments in rates for claims experience, health
332 status, or duration of coverage may not be charged to individual
333 employees or dependents. For a small employer's policy, such
334 adjustments may not result in a rate for the small employer
335 which deviates more than 15 percent from the carrier's approved
336 rate. Any such adjustment must be applied uniformly to the rates
337 charged for all employees and dependents of the small employer.
338 A small employer carrier may make an adjustment to a small

339 employer's renewal premium, up to 10 percent annually, due to
340 the claims experience, health status, or duration of coverage of
341 the employees or dependents of the small employer. ~~Semiannually,~~
342 ~~small group carriers shall report information on forms adopted~~
343 ~~by rule by the commission, to enable the office to monitor the~~
344 ~~relationship of aggregate adjusted premiums actually charged~~
345 ~~policyholders by each carrier to the premiums that would have~~
346 ~~been charged by application of the carrier's approved modified~~
347 ~~community rates.~~ If the aggregate resulting from the application
348 of such adjustment exceeds the premium that would have been
349 charged by application of the approved modified community rate
350 by 4 percent for the current policy term ~~reporting period~~, the
351 carrier shall limit the application of such adjustments only to
352 minus adjustments ~~beginning within 60 days after the report is~~
353 ~~sent to the office~~. For any subsequent policy term ~~reporting~~
354 ~~period~~, if the total aggregate adjusted premium actually charged
355 does not exceed the premium that would have been charged by
356 application of the approved modified community rate by 4
357 percent, the carrier may apply both plus and minus adjustments.
358 A small employer carrier may provide a credit to a small
359 employer's premium based on administrative and acquisition
360 expense differences resulting from the size of the group. Group
361 size administrative and acquisition expense factors may be
362 developed by each carrier to reflect the carrier's experience
363 and are subject to office review and approval.
364 6. A small employer carrier rating methodology may include

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

365 separate rating categories for one dependent child, for two
366 dependent children, and for three or more dependent children for
367 family coverage of employees having a spouse and dependent
368 children or employees having dependent children only. A small
369 employer carrier may have fewer, but not greater, numbers of
370 categories for dependent children than those specified in this
371 subparagraph.
372 7. Small employer carriers may not use a composite rating
373 methodology to rate a small employer with fewer than 10
374 employees. For the purposes of this subparagraph, the term
375 "composite rating methodology" means a rating methodology that
376 averages the impact of the rating factors for age and gender in
377 the premiums charged to all of the employees of a small
378 employer.
379 8. A carrier may separate the experience of small employer
380 groups with fewer than 2 eligible employees from the experience
381 of small employer groups with 2-50 eligible employees for
382 purposes of determining an alternative modified community
383 rating.
384 a. If a carrier separates the experience of small employer
385 groups, the rate to be charged to small employer groups of fewer
386 than 2 eligible employees may not exceed 150 percent of the rate
387 determined for small employer groups of 2-50 eligible employees.
388 However, the carrier may charge excess losses of the experience
389 pool consisting of small employer groups with less than 2
390 eligible employees to the experience pool consisting of small

391 employer groups with 2-50 eligible employees so that all losses
392 are allocated and the 150-percent rate limit on the experience
393 pool consisting of small employer groups with less than 2
394 eligible employees is maintained.
395 b. Notwithstanding s. 627.411(1), the rate to be charged
396 to a small employer group of fewer than 2 eligible employees,
397 insured as of July 1, 2002, may be up to 125 percent of the rate
398 determined for small employer groups of 2-50 eligible employees
399 for the first annual renewal and 150 percent for subsequent
400 annual renewals.
401 9. A carrier shall separate the experience of
402 grandfathered health plans from nongrandfathered health plans
403 for determining rates.
404 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—
405 (g) A reinsuring carrier may reinsure with the program
406 coverage of an eligible employee of a small employer, or any
407 dependent of such an employee, subject to each of the following
408 provisions:
409 ~~1. With respect to a standard and basic health care plan,~~
410 ~~the program must reinsure the level of coverage provided; and,~~
411 ~~with respect to any other plan, the program must reinsure the~~
412 ~~coverage up to, but not exceeding, the level of coverage~~
413 ~~provided under the standard and basic health care plan.~~
414 1.~~2.~~ Except in the case of a late enrollee, a reinsuring
415 carrier may reinsure an eligible employee or dependent within 60
416 days after the commencement of the coverage of the small

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

417 employer. A newly employed eligible employee or dependent of a
418 small employer may be reinsured within 60 days after the
419 commencement of his or her coverage.
420 <u>2.</u>~~3.~~ A small employer carrier may reinsure an entire
421 employer group within 60 days after the commencement of the
422 group's coverage under the plan. ~~The carrier may choose to~~
423 ~~reinsure newly eligible employees and dependents of the~~
424 ~~reinsured group pursuant to subparagraph 1.~~
425 <u>3.</u>~~4.~~ The program may not reimburse a participating carrier
426 with respect to the claims of a reinsured employee or dependent
427 until the carrier has paid incurred claims of at least $5,000 in
428 a calendar year for benefits covered by the program. In
429 addition, the reinsuring carrier shall be responsible for 10
430 percent of the next $50,000 and 5 percent of the next $100,000
431 of incurred claims during a calendar year and the program shall
432 reinsure the remainder.
433 <u>4.</u>~~5.~~ The board annually shall adjust the initial level of
434 claims and the maximum limit to be retained by the carrier to
435 reflect increases in costs and utilization within the standard
436 market for health benefit plans within the state. The adjustment
437 shall not be less than the annual change in the medical
438 component of the "Consumer Price Index for All Urban Consumers"
439 of the Bureau of Labor Statistics of the Department of Labor,
440 unless the board proposes and the office approves a lower
441 adjustment factor.
442 <u>5.</u>~~6.~~ A small employer carrier may terminate reinsurance

443 for all reinsured employees or dependents on any plan
444 anniversary.
445 6. ~~7.~~ The premium rate charged for reinsurance by the
446 program to a health maintenance organization that is approved by
447 the Secretary of Health and Human Services as a federally
448 qualified health maintenance organization pursuant to 42 U.S.C.
449 s. 300e(c)(2)(A) and that, as such, is subject to requirements
450 that limit the amount of risk that may be ceded to the program,
451 which requirements are more restrictive than subparagraph 3. ~~4.~~,
452 shall be reduced by an amount equal to that portion of the risk,
453 if any, which exceeds the amount set forth in subparagraph 3. ~~4.~~
454 which may not be ceded to the program.
455 7. ~~8.~~ The board may consider adjustments to the premium
456 rates charged for reinsurance by the program for carriers that
457 use effective cost containment measures, including high-cost
458 case management, as defined by the board.
459 8. ~~9.~~ A reinsuring carrier shall apply its case-management
460 and claims-handling techniques, including, but not limited to,
461 utilization review, individual case management, preferred
462 provider provisions, other managed care provisions or methods of
463 operation, consistently with both reinsured business and
464 nonreinsured business.
465 (h)1. The board, as part of the plan of operation, shall
466 establish a methodology for determining premium rates to be
467 charged by the program for reinsuring small employers and
468 individuals pursuant to this section. The methodology shall

469 include a system for classification of small employers that
470 reflects the types of case characteristics commonly used by
471 small employer carriers in the state. The methodology shall
472 provide for the development of basic reinsurance premium rates,
473 which shall be multiplied by the factors set for them in this
474 paragraph to determine the premium rates for the program. The
475 basic reinsurance premium rates shall be established by the
476 board, subject to the approval of the office~~, and shall be set~~
477 ~~at levels which reasonably approximate gross premiums charged to~~
478 ~~small employers by small employer carriers for health benefit~~
479 ~~plans with benefits similar to the standard and basic health~~
480 ~~benefit plan~~. The premium rates set by the board may vary by
481 geographical area, as determined under this section, to reflect
482 differences in cost. The multiplying factors must be established
483 as follows:
484 a. The entire group may be reinsured for a rate that is
485 1.5 times the rate established by the board.
486 b. An eligible employee or dependent may be reinsured for
487 a rate that is 5 times the rate established by the board.
488 2. The board periodically shall review the methodology
489 established, including the system of classification and any
490 rating factors, to assure that it reasonably reflects the claims
491 experience of the program. The board may propose changes to the
492 rates which shall be subject to the approval of the office.
493 (j)1. Before July 1 of each calendar year, the board shall
494 determine and report to the office the program net loss for the

495 previous year, including administrative expenses for that year,
496 and the incurred losses for the year, taking into account
497 investment income and other appropriate gains and losses.
498 2. Any net loss for the year shall be recouped by
499 assessment of the carriers, as follows:
500 a. The operating losses of the program shall be assessed
501 in the following order subject to the specified limitations. The
502 first tier of assessments shall be made against reinsuring
503 carriers in an amount which shall not exceed 5 percent of each
504 reinsuring carrier's premiums from health benefit plans covering
505 small employers. If such assessments have been collected and
506 additional moneys are needed, the board shall make a second tier
507 of assessments in an amount which shall not exceed 0.5 percent
508 of each carrier's health benefit plan premiums. Except as
509 provided in paragraph (m) ~~(n)~~, risk-assuming carriers are exempt
510 from all assessments authorized pursuant to this section. The
511 amount paid by a reinsuring carrier for the first tier of
512 assessments shall be credited against any additional assessments
513 made.
514 b. The board shall equitably assess carriers for operating
515 losses of the plan based on market share. The board shall
516 annually assess each carrier a portion of the operating losses
517 of the plan. The first tier of assessments shall be determined
518 by multiplying the operating losses by a fraction, the numerator
519 of which equals the reinsuring carrier's earned premium
520 pertaining to direct writings of small employer health benefit

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

521 plans in the state during the calendar year for which the
522 assessment is levied, and the denominator of which equals the
523 total of all such premiums earned by reinsuring carriers in the
524 state during that calendar year. The second tier of assessments
525 shall be based on the premiums that all carriers, except risk-
526 assuming carriers, earned on all health benefit plans written in
527 this state. The board may levy interim assessments against
528 carriers to ensure the financial ability of the plan to cover
529 claims expenses and administrative expenses paid or estimated to
530 be paid in the operation of the plan for the calendar year prior
531 to the association's anticipated receipt of annual assessments
532 for that calendar year. Any interim assessment is due and
533 payable within 30 days after receipt by a carrier of the interim
534 assessment notice. Interim assessment payments shall be credited
535 against the carrier's annual assessment. Health benefit plan
536 premiums and benefits paid by a carrier that are less than an
537 amount determined by the board to justify the cost of collection
538 may not be considered for purposes of determining assessments.
539 c. Subject to the approval of the office, the board shall
540 make an adjustment to the assessment formula for reinsuring
541 carriers that are approved as federally qualified health
542 maintenance organizations by the Secretary of Health and Human
543 Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,
544 if any, that restrictions are placed on them that are not
545 imposed on other small employer carriers.
546 3. Before July 1 of each year, the board shall determine

547 and file with the office an estimate of the assessments needed
548 to fund the losses incurred by the program in the previous
549 calendar year.
550 4. If the board determines that the assessments needed to
551 fund the losses incurred by the program in the previous calendar
552 year will exceed the amount specified in subparagraph 2., the
553 board shall evaluate the operation of the program and report its
554 findings, including any recommendations for changes to the plan
555 of operation, to the office within 180 days following the end of
556 the calendar year in which the losses were incurred. The
557 evaluation shall include an estimate of future assessments, the
558 administrative costs of the program, the appropriateness of the
559 premiums charged and the level of carrier retention under the
560 program, and the costs of coverage for small employers. If the
561 board fails to file a report with the office within 180 days
562 following the end of the applicable calendar year, the office
563 may evaluate the operations of the program and implement such
564 amendments to the plan of operation the office deems necessary
565 to reduce future losses and assessments.
566 5. If assessments exceed the amount of the actual losses
567 and administrative expenses of the program, the excess shall be
568 held as interest and used by the board to offset future losses
569 or to reduce program premiums. As used in this paragraph, the
570 term "future losses" includes reserves for incurred but not
571 reported claims.
572 6. Each carrier's proportion of the assessment shall be

573 determined annually by the board, based on annual statements and
574 other reports considered necessary by the board and filed by the
575 carriers with the board.
576 7. Provision shall be made in the plan of operation for
577 the imposition of an interest penalty for late payment of an
578 assessment.
579 8. A carrier may seek, from the office, a deferment, in
580 whole or in part, from any assessment made by the board. The
581 office may defer, in whole or in part, the assessment of a
582 carrier if, in the opinion of the office, the payment of the
583 assessment would place the carrier in a financially impaired
584 condition. If an assessment against a carrier is deferred, in
585 whole or in part, the amount by which the assessment is deferred
586 may be assessed against the other carriers in a manner
587 consistent with the basis for assessment set forth in this
588 section. The carrier receiving such deferment remains liable to
589 the program for the amount deferred and is prohibited from
590 reinsuring any individuals or groups in the program if it fails
591 to pay assessments.
592 ~~(l) The board, as part of the plan of operation, shall~~
593 ~~develop standards setting forth the manner and levels of~~
594 ~~compensation to be paid to agents for the sale of basic and~~
595 ~~standard health benefit plans. In establishing such standards,~~
596 ~~the board shall take into consideration the need to assure the~~
597 ~~broad availability of coverages, the objectives of the program,~~
598 ~~the time and effort expended in placing the coverage, the need~~

599 ~~to provide ongoing service to the small employer, the levels of~~
600 ~~compensation currently used in the industry, and the overall~~
601 ~~costs of coverage to small employers selecting these plans.~~
602 (l) ~~(m)~~ The board shall monitor compliance with this
603 section, including the market conduct of small employer
604 carriers, and shall report to the office any unfair trade
605 practices and misleading or unfair conduct by a small employer
606 carrier that has been reported to the board by agents,
607 consumers, or any other person. The office shall investigate all
608 reports and, upon a finding of noncompliance with this section
609 or of unfair or misleading practices, shall take action against
610 the small employer carrier as permitted under the insurance code
611 or chapter 641. The board is not given investigatory or
612 regulatory powers, but must forward all reports of cases or
613 abuse or misrepresentation to the office.
614 (m) ~~(n)~~ Notwithstanding paragraph (j), the administrative
615 expenses of the program shall be recouped by assessment of risk-
616 assuming carriers and reinsuring carriers and such amounts shall
617 not be considered part of the operating losses of the plan for
618 the purposes of this paragraph. Each carrier's portion of such
619 administrative expenses shall be determined by multiplying the
620 total of such administrative expenses by a fraction, the
621 numerator of which equals the carrier's earned premium
622 pertaining to direct writing of small employer health benefit
623 plans in the state during the calendar year for which the
624 assessment is levied, and the denominator of which equals the

625 total of such premiums earned by all carriers in the state
626 during such calendar year.
627 (n) ~~(o)~~ The board shall advise the office, the Agency for
628 Health Care Administration, the department, other executive
629 departments, and the Legislature on health insurance issues.
630 Specifically, the board shall:
631 1. Provide a forum for stakeholders, consisting of
632 insurers, employers, agents, consumers, and regulators, in the
633 private health insurance market in this state.
634 2. Review and recommend strategies to improve the
635 functioning of the health insurance markets in this state with a
636 specific focus on market stability, access, and pricing.
637 3. Make recommendations to the office for legislation
638 addressing health insurance market issues and provide comments
639 on health insurance legislation proposed by the office.
640 4. Meet at least three times each year. One meeting shall
641 be held to hear reports and to secure public comment on the
642 health insurance market, to develop any legislation needed to
643 address health insurance market issues, and to provide comments
644 on health insurance legislation proposed by the office.
645 5. Issue a report to the office on the state of the health
646 insurance market by September 1 each year. The report shall
647 include recommendations for changes in the health insurance
648 market, results from implementation of previous recommendations,
649 and information on health insurance markets.
650 ~~(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH~~

651 ~~BENEFIT PLANS.—~~
652 ~~(a)1. The Chief Financial Officer shall appoint a health~~
653 ~~benefit plan committee composed of four representatives of~~
654 ~~carriers which shall include at least two representatives of~~
655 ~~HMOs, at least one of which is a staff model HMO, two~~
656 ~~representatives of agents, four representatives of small~~
657 ~~employers, and one employee of a small employer. The carrier~~
658 ~~members shall be selected from a list of individuals recommended~~
659 ~~by the board. The Chief Financial Officer may require the board~~
660 ~~to submit additional recommendations of individuals for~~
661 ~~appointment.~~
662 ~~2. The plans shall comply with all of the requirements of~~
663 ~~this subsection.~~
664 ~~3. The plans must be filed with and approved by the office~~
665 ~~prior to issuance or delivery by any small employer carrier.~~
666 ~~4. After approval of the revised health benefit plans, if~~
667 ~~the office determines that modifications to a plan might be~~
668 ~~appropriate, the Chief Financial Officer shall appoint a new~~
669 ~~health benefit plan committee in the manner provided in~~
670 ~~subparagraph 1. to submit recommended modifications to the~~
671 ~~office for approval.~~
672 ~~(b)1. Each small employer carrier issuing new health~~
673 ~~benefit plans shall offer to any small employer, upon request, a~~
674 ~~standard health benefit plan, a basic health benefit plan, and a~~
675 ~~high deductible plan that meets the requirements of a health~~
676 ~~savings account plan as defined by federal law or a health~~

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

677 ~~reimbursement arrangement as authorized by the Internal Revenue~~
678 ~~Service, that meet the criteria set forth in this section.~~
679 ~~2. For purposes of this subsection, the terms "standard~~
680 ~~health benefit plan," "basic health benefit plan," and "high~~
681 ~~deductible plan" mean policies or contracts that a small~~
682 ~~employer carrier offers to eligible small employers that~~
683 ~~contain:~~
684 ~~a. An exclusion for services that are not medically~~
685 ~~necessary or that are not covered preventive health services;~~
686 ~~and~~
687 ~~b. A procedure for preauthorization by the small employer~~
688 ~~carrier, or its designees.~~
689 ~~3. A small employer carrier may include the following~~
690 ~~managed care provisions in the policy or contract to control~~
691 ~~costs:~~
692 ~~a. A preferred provider arrangement or exclusive provider~~
693 ~~organization or any combination thereof, in which a small~~
694 ~~employer carrier enters into a written agreement with the~~
695 ~~provider to provide services at specified levels of~~
696 ~~reimbursement or to provide reimbursement to specified~~
697 ~~providers. Any such written agreement between a provider and a~~
698 ~~small employer carrier must contain a provision under which the~~
699 ~~parties agree that the insured individual or covered member has~~
700 ~~no obligation to make payment for any medical service rendered~~
701 ~~by the provider which is determined not to be medically~~
702 ~~necessary. A carrier may use preferred provider arrangements or~~

703 ~~exclusive provider arrangements to the same extent as allowed in~~
704 ~~group products that are not issued to small employers.~~
705 ~~b. A procedure for utilization review by the small~~
706 ~~employer carrier or its designees.~~
707
708 ~~This subparagraph does not prohibit a small employer carrier~~
709 ~~from including in its policy or contract additional managed care~~
710 ~~and cost containment provisions, subject to the approval of the~~
711 ~~office, which have potential for controlling costs in a manner~~
712 ~~that does not result in inequitable treatment of insureds or~~
713 ~~subscribers. The carrier may use such provisions to the same~~
714 ~~extent as authorized for group products that are not issued to~~
715 ~~small employers.~~
716 ~~4. The standard health benefit plan shall include:~~
717 ~~a. Coverage for inpatient hospitalization;~~
718 ~~b. Coverage for outpatient services;~~
719 ~~c. Coverage for newborn children pursuant to s. 627.6575;~~
720 ~~d. Coverage for child care supervision services pursuant~~
721 ~~to s. 627.6579;~~
722 ~~e. Coverage for adopted children upon placement in the~~
723 ~~residence pursuant to s. 627.6578;~~
724 ~~f. Coverage for mammograms pursuant to s. 627.6613;~~
725 ~~g. Coverage for handicapped children pursuant to s.~~
726 ~~627.6615;~~
727 ~~h. Emergency or urgent care out of the geographic service~~
728 ~~area; and~~

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

729 ~~i. Coverage for services provided by a hospice licensed~~
730 ~~under s. 400.602 in cases where such coverage would be the most~~
731 ~~appropriate and the most cost-effective method for treating a~~
732 ~~covered illness.~~
733 ~~5. The standard health benefit plan and the basic health~~
734 ~~benefit plan may include a schedule of benefit limitations for~~
735 ~~specified services and procedures. If the committee develops~~
736 ~~such a schedule of benefits limitation for the standard health~~
737 ~~benefit plan or the basic health benefit plan, a small employer~~
738 ~~carrier offering the plan must offer the employer an option for~~
739 ~~increasing the benefit schedule amounts by 4 percent annually.~~
740 ~~6. The basic health benefit plan shall include all of the~~
741 ~~benefits specified in subparagraph 4.; however, the basic health~~
742 ~~benefit plan shall place additional restrictions on the benefits~~
743 ~~and utilization and may also impose additional cost containment~~
744 ~~measures.~~
745 ~~7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612,~~
746 ~~627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911~~
747 ~~apply to the standard health benefit plan and to the basic~~
748 ~~health benefit plan. However, notwithstanding said provisions,~~
749 ~~the plans may specify limits on the number of authorized~~
750 ~~treatments, if such limits are reasonable and do not~~
751 ~~discriminate against any type of provider.~~
752 ~~8. The high deductible plan associated with a health~~
753 ~~savings account or a health reimbursement arrangement shall~~
754 ~~include all the benefits specified in subparagraph 4.~~

755 ~~9. Each small employer carrier that provides for inpatient~~
756 ~~and outpatient services by allopathic hospitals may provide as~~
757 ~~an option of the insured similar inpatient and outpatient~~
758 ~~services by hospitals accredited by the American Osteopathic~~
759 ~~Association when such services are available and the osteopathic~~
760 ~~hospital agrees to provide the service.~~
761 ~~(c) If a small employer rejects, in writing, the standard~~
762 ~~health benefit plan, the basic health benefit plan, and the high~~
763 ~~deductible health savings account plan or a health reimbursement~~
764 ~~arrangement, the small employer carrier may offer the small~~
765 ~~employer a limited benefit policy or contract.~~
766 ~~(d)1. Upon offering coverage under a standard health~~
767 ~~benefit plan, a basic health benefit plan, or a limited benefit~~
768 ~~policy or contract for a small employer group, the small~~
769 ~~employer carrier shall provide such employer group with a~~
770 ~~written statement that contains, at a minimum:~~
771 ~~a. An explanation of those mandated benefits and providers~~
772 ~~that are not covered by the policy or contract;~~
773 ~~b. An explanation of the managed care and cost control~~
774 ~~features of the policy or contract, along with all appropriate~~
775 ~~mailing addresses and telephone numbers to be used by insureds~~
776 ~~in seeking information or authorization; and~~
777 ~~c. An explanation of the primary and preventive care~~
778 ~~features of the policy or contract.~~
779
780 ~~Such disclosure statement must be presented in a clear and~~

781 ~~understandable form and format and must be separate from the~~
782 ~~policy or certificate or evidence of coverage provided to the~~
783 ~~employer group.~~
784 ~~2. Before a small employer carrier issues a standard~~
785 ~~health benefit plan, a basic health benefit plan, or a limited~~
786 ~~benefit policy or contract, the carrier must obtain from the~~
787 ~~prospective policyholder a signed written statement in which the~~
788 ~~prospective policyholder:~~
789 ~~a. Certifies as to eligibility for coverage under the~~
790 ~~standard health benefit plan, basic health benefit plan, or~~
791 ~~limited benefit policy or contract;~~
792 ~~b. Acknowledges the limited nature of the coverage and an~~
793 ~~understanding of the managed care and cost control features of~~
794 ~~the policy or contract;~~
795 ~~c. Acknowledges that if misrepresentations are made~~
796 ~~regarding eligibility for coverage under a standard health~~
797 ~~benefit plan, a basic health benefit plan, or a limited benefit~~
798 ~~policy or contract, the person making such misrepresentations~~
799 ~~forfeits coverage provided by the policy or contract; and~~
800 ~~d. If a limited plan is requested, acknowledges that the~~
801 ~~prospective policyholder had been offered, at the time of~~
802 ~~application for the insurance policy or contract, the~~
803 ~~opportunity to purchase any health benefit plan offered by the~~
804 ~~carrier and that the prospective policyholder rejected that~~
805 ~~coverage.~~
806

807 ~~A copy of such written statement must be provided to the~~
808 ~~prospective policyholder by the time of delivery of the policy~~
809 ~~or contract, and the original of such written statement must be~~
810 ~~retained in the files of the small employer carrier for the~~
811 ~~period of time that the policy or contract remains in effect or~~
812 ~~for 5 years, whichever is longer.~~
813 ~~3. Any material statement made by an applicant for~~
814 ~~coverage under a health benefit plan which falsely certifies the~~
815 ~~applicant's eligibility for coverage serves as the basis for~~
816 ~~terminating coverage under the policy or contract.~~
817 ~~(c) A small employer carrier may not use any policy,~~
818 ~~contract, form, or rate under this section, including~~
819 ~~applications, enrollment forms, policies, contracts,~~
820 ~~certificates, evidences of coverage, riders, amendments,~~
821 ~~endorsements, and disclosure forms, until the insurer has filed~~
822 ~~it with the office and the office has approved it under ss.~~
823 ~~627.410 and 627.411 and this section.~~
824 (12)~~(13)~~ STANDARDS TO ASSURE FAIR MARKETING.—
825 (a) Each small employer carrier shall actively market
826 health benefit plan coverage~~, including the basic and standard~~
827 ~~health benefit plans~~, including any subsequent modifications or
828 additions to those plans, to eligible small employers in the
829 state. ~~Before January 1, 1994, if a small employer carrier~~
830 ~~denies coverage to a small employer on the basis of the health~~
831 ~~status or claims experience of the small employer or its~~
832 ~~employees or dependents, the small employer carrier shall offer~~

833 ~~the small employer the opportunity to purchase a basic health~~
834 ~~benefit plan and a standard health benefit plan. Beginning~~
835 ~~January 1, 1994,~~ Small employer carriers must offer and issue
836 all plans on a guaranteed-issue basis.
837 (b) A ~~No~~ small employer carrier or agent shall not,
838 directly or indirectly, engage in the following activities:
839 1. Encouraging or directing small employers to refrain
840 from filing an application for coverage with the small employer
841 carrier because of the health status, claims experience,
842 industry, occupation, or geographic location of the small
843 employer.
844 2. Encouraging or directing small employers to seek
845 coverage from another carrier because of the health status,
846 claims experience, industry, occupation, or geographic location
847 of the small employer.
848 (c) ~~The provisions of~~ Paragraph (a) does ~~shall~~ not apply
849 with respect to information provided by a small employer carrier
850 or agent to a small employer regarding the established
851 geographic service area or a restricted network provision of a
852 small employer carrier.
853 (d) A ~~No~~ small employer carrier shall not, directly or
854 indirectly, enter into any contract, agreement, or arrangement
855 with an agent that provides for or results in the compensation
856 paid to an agent for the sale of a health benefit plan to be
857 varied because of the health status, claims experience,
858 industry, occupation, or geographic location of the small

859 employer except if the compensation arrangement provides
860 compensation to an agent on the basis of percentage of premium,
861 provided that the percentage shall not vary because of the
862 health status, claims experience, industry, occupation, or
863 geographic area of the small employer.
864 ~~(c) A small employer carrier shall provide reasonable~~
865 ~~compensation, as provided under the plan of operation of the~~
866 ~~program, to an agent, if any, for the sale of a basic or~~
867 ~~standard health benefit plan.~~
868 (e) ~~(f)~~ A ~~No~~ small employer carrier shall not terminate,
869 fail to renew, or limit its contract or agreement of
870 representation with an agent for any reason related to the
871 health status, claims experience, occupation, or geographic
872 location of the small employers placed by the agent with the
873 small employer carrier unless the agent consistently engages in
874 practices that violate this section or s. 626.9541.
875 (f) ~~(g)~~ A ~~No~~ small employer carrier or agent shall not
876 induce or otherwise encourage a small employer to separate or
877 otherwise exclude an employee from health coverage or benefits
878 provided in connection with the employee's employment.
879 (g) ~~(h)~~ Denial by a small employer carrier of an
880 application for coverage from a small employer shall be in
881 writing and shall state the reason or reasons for the denial.
882 (h) ~~(i)~~ The commission may establish regulations setting
883 forth additional standards to provide for the fair marketing and
884 broad availability of health benefit plans to small employers in

885 this state.

886 (i) ~~(j)~~ A violation of this section by a small employer
887 carrier or an agent is ~~shall be~~ an unfair trade practice under
888 s. 626.9541 or ss. 641.3903 and 641.3907.

889 (j) ~~(k)~~ If a small employer carrier enters into a contract,
890 agreement, or other arrangement with a third-party administrator
891 to provide administrative, marketing, or other services relating
892 to the offering of health benefit plans to small employers in
893 this state, the third-party administrator shall be subject to
894 this section.

895 (13) ~~(14)~~ DISCLOSURE OF INFORMATION.—

896 (a) In connection with the offering of a health benefit
897 plan to a small employer, a small employer carrier:

898 1. Shall make a reasonable disclosure to such employer, as
899 part of its solicitation and sales materials, of the
900 availability of information described in paragraph (b); and

901 2. Upon request of the small employer, provide such
902 information.

903 (b)1. Subject to subparagraph 3., with respect to a small
904 employer carrier that offers a health benefit plan to a small
905 employer, information described in this paragraph is information
906 that concerns:

907 a. The provisions of such coverage concerning an insurer's
908 right to change premium rates and the factors that may affect
909 changes in premium rates;

910 b. The provisions of such coverage that relate to

911 renewability of coverage;
912 c. The provisions of such coverage that relate to any
913 preexisting condition exclusions; and
914 d. The benefits and premiums available under all health
915 insurance coverage for which the employer is qualified.
916 2. Information required under this subsection shall be
917 provided to small employers in a manner determined to be
918 understandable by the average small employer, and shall be
919 sufficient to reasonably inform small employers of their rights
920 and obligations under the health insurance coverage.
921 3. An insurer is not required under this subsection to
922 disclose any information that is proprietary or a trade secret
923 under state law.
924 (14)~~(15)~~ SMALL EMPLOYERS ACCESS PROGRAM.—
925 (k) Benefits.~~—The benefits provided by the plan shall be~~
926 ~~the same as the coverage required for small employers under~~
927 ~~subsection (12).~~ Upon the approval of the office, the insurer
928 may ~~also~~ establish an optional mutually supported benefit plan
929 that ~~which~~ is an alternative plan developed within a defined
930 geographic region of this state or any other such alternative
931 plan that ~~which~~ will carry out the intent of this subsection.
932 Any small employer carrier issuing new health benefit plans may
933 offer a benefit plan with coverages similar to, but not less
934 than, any alternative coverage plan developed pursuant to this
935 subsection.
936 (15)~~(16)~~ APPLICABILITY OF OTHER STATE LAWS.—

937 (a) Except as expressly provided in this section, a law
938 requiring coverage for a specific health care service or
939 benefit, or a law requiring reimbursement, utilization, or
940 consideration of a specific category of licensed health care
941 practitioner, does not apply to ~~a standard or basic health~~
942 ~~benefit plan policy or contract or~~ a limited benefit policy or
943 contract offered or delivered to a small employer unless that
944 law is made expressly applicable to such policies or contracts.
945 A law restricting or limiting deductibles, coinsurance,
946 copayments, or annual or lifetime maximum payments does not
947 apply to any health plan policy~~, including a standard or basic~~
948 ~~health benefit plan policy or contract,~~ offered or delivered to
949 a small employer unless such law is made expressly applicable to
950 such policy or contract. ~~However, every small employer carrier~~
951 ~~must offer to eligible small employers the standard benefit plan~~
952 ~~and the basic benefit plan, as required by subsection (5), as~~
953 ~~such plans have been approved by the office pursuant to~~
954 ~~subsection (12).~~
955 ~~(b) Except as provided in this section, a standard or~~
956 ~~basic health benefit plan policy or contract or limited benefit~~
957 ~~policy or contract offered to a small employer is not subject to~~
958 ~~any provision of this code which:~~
959 ~~1. Inhibits a small employer carrier from contracting with~~
960 ~~providers or groups of providers with respect to health care~~
961 ~~services or benefits;~~
962 ~~2. Imposes any restriction on a small employer carrier's~~

963 ~~ability to negotiate with providers regarding the level or~~
964 ~~method of reimbursing care or services provided under a health~~
965 ~~benefit plan; or~~
966 ~~3. Requires a small employer carrier to either include a~~
967 ~~specific provider or class of providers when contracting for~~
968 ~~health care services or benefits or to exclude any class of~~
969 ~~providers that is generally authorized by statute to provide~~
970 ~~such care.~~
971 (b)~~(c)~~ Any second tier assessment paid by a carrier
972 pursuant to paragraph (11)(j) may be credited against
973 assessments levied against the carrier pursuant to s. 627.6494.
974 (c)~~(d)~~ Notwithstanding chapter 641, a health maintenance
975 organization may ~~is authorized to~~ issue contracts providing
976 benefits equal to the ~~standard health benefit plan, the basic~~
977 ~~health benefit plan, and the~~ limited benefit policy authorized
978 by this section.
979 (16)~~(17)~~ RESTRICTIONS ON COVERAGE.—
980 (a) A plan under which coverage is purchased in whole or
981 in part with any state or federal funds through an exchange
982 created pursuant to the federal Patient Protection and
983 Affordable Care Act, Pub. L. No. 111-148, may not provide
984 coverage for an abortion, as defined in s. 390.011(1), except if
985 the pregnancy is the result of an act of rape or incest, or in
986 the case where a woman suffers from a physical disorder,
987 physical injury, or physical illness, including a life-
988 endangering physical condition caused by or arising from the

989 pregnancy itself, which would, as certified by a physician,
990 place the woman in danger of death unless an abortion is
991 performed. Coverage is deemed to be purchased with state or
992 federal funds if any tax credit or cost-sharing credit is
993 applied toward the plan.
994 (b) This subsection does not prohibit a plan from
995 providing any person or entity with separate coverage for an
996 abortion if such coverage is not purchased in whole or in part
997 with state or federal funds.
998 (c) As used in this section, the term "state" means this
999 state or any political subdivision of the state.
1000 (17) ~~(18)~~ RULEMAKING AUTHORITY.—The commission may adopt
1001 rules to administer this section, including rules governing
1002 compliance by small employer carriers and small employers.
1003 Section 2. Section 627.66997, Florida Statutes, is created
1004 to read:
1005 627.66997 Stop-loss insurance.—
1006 (1) A self-insured health benefit plan established or
1007 maintained by a small employer, as defined in s. 627.6699(3)(v),
1008 is exempt from s. 627.6699 and may use a stop-loss insurance
1009 policy issued to the employer. For purposes of this section, the
1010 term "stop-loss insurance policy" means a health insurance
1011 policy issued to a small employer which covers the small
1012 employer's obligation for the excess cost of medical care on an
1013 equivalent basis per employee provided under a self-insured
1014 health benefit plan. Except as provided in subsection (2), a

1015 stop-loss insurance policy is exempt from s. 627.6699.
1016 (2) A stop-loss insurance policy is subject to s. 627.6699
1017 if the policy has an aggregate attachment point that is lower
1018 than the greatest of:
1019 (a) Two thousand dollars multiplied by the number of
1020 employees;
1021 (b) One hundred twenty percent of expected claims, as
1022 determined by the stop-loss insurer in accordance with actuarial
1023 standards of practice; or
1024 (c) Twenty thousand dollars.
1025 (3) A stop-loss insurance policy authorized under this
1026 section must cover 100 percent of all claims equal to or above
1027 the attachment point set forth in subsection (2).
1028 (4) Health insurance carriers shall use a consistent basis
1029 for determining the number of an employer's covered employees.
1030 Such basis may include, but is not limited to, the average
1031 number of employees employed annually or at a uniform time.
1032 Section 3. Subsection (3) of section 627.642, Florida
1033 Statutes, is amended to read:
1034 627.642 Outline of coverage.—
1035 (3) In addition to the outline of coverage, a policy as
1036 specified in s. 627.6699(3)(k) ~~627.6699(3)(l)~~ must be
1037 accompanied by an identification card that contains, at a
1038 minimum:
1039 (a) The name of the organization issuing the policy or the
1040 name of the organization administering the policy, whichever

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

1041 applies.
1042 (b) The name of the contract holder.
1043 (c) The type of plan only if the plan is filed in the
1044 state, an indication that the plan is self-funded, or the name
1045 of the network.
1046 (d) The member identification number, contract number, and
1047 policy or group number, if applicable.
1048 (e) A contact phone number or electronic address for
1049 authorizations and admission certifications.
1050 (f) A phone number or electronic address whereby the
1051 covered person or hospital, physician, or other person rendering
1052 services covered by the policy may obtain benefits verification
1053 and information in order to estimate patient financial
1054 responsibility, in compliance with privacy rules under the
1055 Health Insurance Portability and Accountability Act.
1056 (g) The national plan identifier, in accordance with the
1057 compliance date set forth by the federal Department of Health
1058 and Human Services.
1059
1060 The identification card must present the information in a
1061 readily identifiable manner or, alternatively, the information
1062 may be embedded on the card and available through magnetic
1063 stripe or smart card. The information may also be provided
1064 through other electronic technology.
1065 Section 4. Paragraph (g) of subsection (7) and paragraph
1066 (a) of subsection (8) of section 627.6475, Florida Statutes, are

1067 amended to read:

1068 627.6475 Individual reinsurance pool.—

1069 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

1070 (g) Except as otherwise provided in this section, the
1071 board and the office shall have all powers, duties, and
1072 responsibilities with respect to carriers that issue and
1073 reinsure individual health insurance, as specified for the board
1074 and the office in s. 627.6699(11) with respect to small employer
1075 carriers, including, but not limited to, the provisions of s.
1076 627.6699(11) relating to:

1077 1. Use of assessments that exceed the amount of actual
1078 losses and expenses.

1079 2. The annual determination of each carrier's proportion
1080 of the assessment.

1081 3. Interest for late payment of assessments.

1082 4. Authority for the office to approve deferment of an
1083 assessment against a carrier.

1084 5. Limited immunity from legal actions or carriers.

1085 6. Development of standards for compensation to be paid to
1086 agents. Such standards shall be limited to those specifically
1087 enumerated in s. 627.6699(12)(d) ~~627.6699(13)(d)~~.

1088 7. Monitoring compliance by carriers with this section.

1089 (8) STANDARDS TO ASSURE FAIR MARKETING.—

1090 (a) Each health insurance issuer that offers individual
1091 health insurance shall actively market coverage to eligible
1092 individuals in the state. The provisions of s. 627.6699(12)

1093 ~~627.6699(13)~~ that apply to small employer carriers that market
1094 policies to small employers shall also apply to health insurance
1095 issuers that offer individual health insurance with respect to
1096 marketing policies to individuals.
1097 Section 5. Subsection (2) of section 627.657, Florida
1098 Statutes, is amended to read:
1099 627.657 Provisions of group health insurance policies.—
1100 (2) The medical policy as specified in s. 627.6699(3)(k)
1101 ~~627.6699(3)(l)~~ must be accompanied by an identification card
1102 that contains, at a minimum:
1103 (a) The name of the organization issuing the policy or
1104 name of the organization administering the policy, whichever
1105 applies.
1106 (b) The name of the certificateholder.
1107 (c) The type of plan only if the plan is filed in the
1108 state, an indication that the plan is self-funded, or the name
1109 of the network.
1110 (d) The member identification number, contract number, and
1111 policy or group number, if applicable.
1112 (e) A contact phone number or electronic address for
1113 authorizations and admission certifications.
1114 (f) A phone number or electronic address whereby the
1115 covered person or hospital, physician, or other person rendering
1116 services covered by the policy may obtain benefits verification
1117 and information in order to estimate patient financial
1118 responsibility, in compliance with privacy rules under the

1119 Health Insurance Portability and Accountability Act.
1120 (g) The national plan identifier, in accordance with the
1121 compliance date set forth by the federal Department of Health
1122 and Human Services.
1123
1124 The identification card must present the information in a
1125 readily identifiable manner or, alternatively, the information
1126 may be embedded on the card and available through magnetic
1127 stripe or smart card. The information may also be provided
1128 through other electronic technology.
1129 Section 6. Paragraph (e) of subsection (2) of section
1130 627.6571, Florida Statutes, is amended to read:
1131 627.6571 Guaranteed renewability of coverage.—
1132 (2) An insurer may nonrenew or discontinue a group health
1133 insurance policy based only on one or more of the following
1134 conditions:
1135 (e) In the case of an insurer that offers health insurance
1136 coverage through a network plan, there is no longer any enrollee
1137 in connection with such plan who lives, resides, or works in the
1138 service area of the insurer or in the area in which the insurer
1139 is authorized to do business ~~and, in the case of the small-group~~
1140 ~~market, the insurer would deny enrollment with respect to such~~
1141 ~~plan under s. 627.6699(5)(i)~~.
1142 Section 7. Subsection (11) of section 627.6675, Florida
1143 Statutes, is amended to read:
1144 627.6675 Conversion on termination of eligibility.—Subject

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

1145 to all of the provisions of this section, a group policy
1146 delivered or issued for delivery in this state by an insurer or
1147 nonprofit health care services plan that provides, on an
1148 expense-incurred basis, hospital, surgical, or major medical
1149 expense insurance, or any combination of these coverages, shall
1150 provide that an employee or member whose insurance under the
1151 group policy has been terminated for any reason, including
1152 discontinuance of the group policy in its entirety or with
1153 respect to an insured class, and who has been continuously
1154 insured under the group policy, and under any group policy
1155 providing similar benefits that the terminated group policy
1156 replaced, for at least 3 months immediately prior to
1157 termination, shall be entitled to have issued to him or her by
1158 the insurer a policy or certificate of health insurance,
1159 referred to in this section as a "converted policy." A group
1160 insurer may meet the requirements of this section by contracting
1161 with another insurer, authorized in this state, to issue an
1162 individual converted policy, which policy has been approved by
1163 the office under s. 627.410. An employee or member shall not be
1164 entitled to a converted policy if termination of his or her
1165 insurance under the group policy occurred because he or she
1166 failed to pay any required contribution, or because any
1167 discontinued group coverage was replaced by similar group
1168 coverage within 31 days after discontinuance.
1169 (11) ALTERNATIVE PLANS.~~The insurer shall, in addition to~~
1170 ~~the option required by subsection (10), offer the standard~~

1171 ~~health benefit plan, as established pursuant to s. 627.6699(12).~~
1172 The insurer may, at its option, ~~also~~ offer alternative plans for
1173 group health conversion in addition to the plans required by
1174 this section.
1175 Section 8. Paragraph (e) of subsection (2) of section
1176 641.31074, Florida Statutes, is amended to read:
1177 641.31074 Guaranteed renewability of coverage.—
1178 (2) A health maintenance organization may nonrenew or
1179 discontinue a contract based only on one or more of the
1180 following conditions:
1181 (e) There is no longer any enrollee in connection with
1182 such plan who lives, resides, or works in the service area of
1183 the health maintenance organization or in the area in which the
1184 health maintenance organization is authorized to do business
1185 ~~and, in the case of the small group market, the organization~~
1186 ~~would deny enrollment with respect to such plan under s.~~
1187 ~~627.6699(5)(i)~~.
1188 Section 9. Subsection (10) of section 641.3922, Florida
1189 Statutes, is amended to read:
1190 641.3922 Conversion contracts; conditions.—Issuance of a
1191 converted contract shall be subject to the following conditions:
1192 (10) ALTERNATE PLANS.~~—The health maintenance organization~~
1193 ~~shall offer a standard health benefit plan as established~~
1194 ~~pursuant to s. 627.6699(12).~~ The health maintenance organization
1195 may, at its option, ~~also~~ offer alternative plans for group
1196 health conversion in addition to those required by this section,

1197 provided any alternative plan is approved by the office or is a
1198 converted policy, approved under s. 627.6675 and issued by an
1199 insurance company authorized to transact insurance in this
1200 state. Approval by the office of an alternative plan shall be
1201 based on compliance by the alternative plan with the provisions
1202 of this part and the rules promulgated thereunder, applicable
1203 provisions of the Florida Insurance Code and rules promulgated
1204 thereunder, and any other applicable law.
1205 Section 10. This act shall take effect July 1, 2015.

Insurance & Banking Subcommittee

CS/HB 731 by Rep. Plakon
Employee Health Care Plans

AMENDMENT SUMMARY
March 18, 2015

Amendment 1 by Rep. Plakon (lines 1005-1031): The amendment creates circumstances for a self-insured health benefit plan established or maintained by an employer with 51 or more covered employees relating to the plan's stop-loss coverage where the plan is considered health insurance. This amendment codifies current OIR rule.

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

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Plakon offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 1005-1031 and insert:
7 627.66997 Stop-loss insurance.—
8 (1) A self-insured health benefit plan established or
9 maintained by a small employer, as defined in s. 627.6699(3)(v),
10 is exempt from s. 627.6699 and may use a stop-loss insurance
11 policy issued to the employer. For purposes of this subsection,
12 the term "stop-loss insurance policy" means an insurance policy
13 issued to a small employer which covers the small employer's
14 obligation for the excess cost of medical care on an equivalent
15 basis per employee provided under a self-insured health benefit
16 plan.

17 (a) A small employer stop-loss insurance policy is
18 considered a health insurance policy and is subject to s.
19 627.6699 if the policy has an aggregate attachment point that is
20 lower than the greatest of:
21 1. Two thousand dollars multiplied by the number of
22 employees;
23 2. One hundred twenty percent of expected claims, as
24 determined by the stop-loss insurer in accordance with actuarial
25 standards of practice; or
26 3. Twenty thousand dollars.
27 (b) Once claims under the small employer health benefit
28 plan reach the aggregate attachment point set forth in paragraph
29 (a), the stop-loss insurance policy authorized under this
30 section must cover 100 percent of all claims that exceed the
31 aggregate attachment point.
32 (2) A self-insured health benefit plan established or
33 maintained by an employer with 51 or more covered employees is
34 considered health insurance if the plan's stop-loss coverage, as
35 defined in s. 627.6482(14), has an aggregate attachment point
36 that is lower than the greater of:
37 (a) One hundred ten percent of expected claims, as
38 determined by the stop-loss insurer in accordance with actuarial
39 standards of practice; or
40 (b) Twenty thousand dollars.
41 (3) Stop-loss insurance carriers shall use a consistent
42 basis for determining the number of an employer's covered

43 employees. Such basis may include, but is not limited to, the
44 average number of employees employed annually or at a uniform
45 time.
46
47 ---
48 **T I T L E A M E N D M E N T**
49 Remove line 10 and insert:
50 authorizing certain health benefit

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 749 Continuing Care Communities
SPONSOR(S): Van Zant and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1126

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	10 Y, 0 N	Guzzo	Poche
2) Insurance & Banking Subcommittee		Bauer	Cooper
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Continuing care communities (CCCs) are retirement facilities that furnish residents with shelter and health care for an entrance fee and monthly payments. CCCs are regulated by the Department of Financial Services, the Agency for Health Care Administration and the Office of Insurance Regulation (OIR). Pursuant to chapter 651, F.S., CCCs are governed by a contract between the facility and the resident. In Florida, continuing care contracts are considered a kind of specialty insurance product and are reviewed and approved by OIR. The OIR authorizes and monitors a facility's operation as well as determines the facility's financial status and the management capabilities of its managers and owners. Currently, there are 71 CCCs in Florida.

A resident of a CCC is required to pay an entrance fee upon entering a contract with a facility. The contract must include the terms for which a resident is due a refund of any portion of the entrance fee. If the contract provides that the resident does not receive a transferable membership or ownership right in the facility, and the resident has occupied his or her unit, the refund must be calculated on a pro-rata basis with the facility retaining up to two-percent per month of occupancy by the resident and up to a five-percent processing fee, the balance of which must be paid within 120 days after the resident gives notice of intent to cancel. Similarly, a contract may provide a one-percent declining-scale refund, but the refund must be paid from the proceeds of the next entrance fees received by the provider for units for which there are no prior claims.

The bill makes several changes to ch. 651, F.S. Specifically, the bill:

- Requires a CCC contract, paying a two-percent refund, to provide for payment to a resident within 90 days after the contract is terminated and the unit is vacated, instead of 120 days after notice of intent to cancel;
- Requires a CCC contract, paying a one-percent refund, to provide for payment to a resident for the unit that is vacated, or a like or similar unit, whichever is applicable, by specified time frames;
- Clarifies that CCCs must be accredited for OIR to waive equivalent requirements in rule or law;
- Makes a CCC contract a preferred claim against a provider in bankruptcy proceedings;
- Requires OIR to notify the executive office of the governing body of the CCC provider about all deficiencies found as part of an examination;
- Requires a CCC to provide a copy of any final examination report and corrective action plan to the executive officer of the governing body of the provider within 60 days after issuance of the report;
- Requires each CCC to establish a residents' council to provide input on subjects that impact the general residential quality of life;
- Authorizes the board of directors or governing board of a provider to allow a facility resident to be a voting member of the board or governing body of the facility; and
- Requires all CCCs to provide a copy of the most recent third-party financial audit to the president or chair of the residents' council within 30 days of filing the annual report with OIR.

The bill does not appear to have a fiscal impact on state or local government. The bill may have a positive impact on the private sector.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Continuing Care Communities (CCCs)

A CCC is a residential alternative for older adults (usually age 65 and older) that provides flexible housing options, a coordinated system of services and amenities, and a lifetime continuum of care that addresses the varying health and wellness needs of residents as they grow older.[1] The foundation of the CCC model is based on enabling residents to move within the community if their health care needs change and they require supervision.[2] The services provided by the CCC and purchased by the resident are governed by contract, or resident service agreement. Entry fees can range from $20,000 to more than $1 million, depending on the geographic location of the CCC, features of the living space, size of the living unit, additional services and amenities selected, whether one or two individuals receive services, and the type of service contract.[3]

There are 1,926 CCCs in the United States.[4] The average number of units in a CCC is 280.[5] Over eighty-percent of CCCs are not-for-profit sponsored, and roughly half of CCCs are faith-based.[6] CCCs feature a combination of living arrangements and nursing beds. There are 71 CCCs in Florida, and a total of 24,775 CCC residents.[7]

The typical accommodations and services include:

- Independent living units – a cottage, townhouse, cluster home, or apartment; the resident is generally healthy and requires little, or no, assistance with activities of daily living.
- Assisted living – a studio or one-bedroom apartment designed for frail individuals who can still maintain a level of independence but need some assistance with activities of daily living.
- Nursing – nursing services are offered on-site or nearby the CCC to provide constant care for recovery from a short-term injury or illness, treatment of a chronic condition, or higher levels of services.
- Memory-care support – offers dedicated cognitive support care with the goal of maximizing function, maintaining dignity, preserving sense of self, and optimizing independence.[8]

In Florida, oversight of CCCs is primarily shared between the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR), pursuant to ch. 651, F.S. ("the Act"). AHCA regulates aspects of CCCs related to the provision of health care such as assisted living, skilled nursing care, quality of care, and concerns with medical facilities.

The Act gives OIR primary responsibility of licensing CCCs, examining them for compliance with applicable laws and rules, and monitoring their financial condition for the protection of the public from

[1] Continuing Care Retirement Community Task Force, Leading Age, American Seniors Housing Association, *Today's Continuing Care Retirement Community*, at page 2 (Jane E. Zarem ed. 2010).
[2] Id.
[3] Id., at page 9.
[4] Ziegler, *Senior Living Overview* (October 8, 2014), at page 26, available at www.flicra.com/pdfs/FLiCRA%20Presentation%2010-8-14.pdf (last visited March 7, 2015).
[5] Id.
[6] Id.
[7] Presentation to the Governor's Continuing Care Advisory Council, September 29, 2014, available at http://www.floir.com/siteDocuments/CouncilPresentation.pdf. (last visited March 7, 2015).
[8] See supra, FN 1, at 4.

insolvency risks and unethical practices.[9] In addition, the Department of Financial Services (DFS) shares some solvency regulatory authority with OIR pursuant to s. 651.114(6), F.S., which provides that OIR and DFS may intervene in CCCs with "all the necessary powers and duties" they possess under the Insurers Rehabilitation and Liquidation Act[10] in regard to delinquency proceedings of insurance companies. As with insurers and other risk-bearing entities, OIR and DFS have coordinated authority to determine the basis for and to initiate delinquency proceedings against CCCs and place them under administrative supervision, rehabilitation, or liquidation.[11]

CCC Certificate of Authority

In order to offer continuing care[12] services in Florida, a provider must be licensed by obtaining a certificate of authority (COA) from OIR.[13] To obtain a COA, each applicant must first apply for and obtain a provisional COA.[14] The OIR is responsible for receiving, reviewing and approving or denying applications for provisional COAs within a specified time period.[15] Upon receipt of a provisional COA, a provider may collect entrance fees and reservation deposits from prospective residents of a proposed continuing care facility.[16]

To obtain a COA, each provider holding a provisional COA must submit additional documentation regarding financing of the proposed facility, receipt of aggregate entrance fees from prospective residents, completed financial audit statements, and other specific information.[17] The OIR is required to issue a COA once it determines that a provider meets all requirements of law, has submitted all necessary information required by statute, has met all escrow requirements, and has paid appropriate fees set out in s. 651.015(2), F.S.[18] Further, a COA will only be issued once a provider submits proof to OIR that a minimum of fifty-percent of the units available, for which entrance fees are being charged, are reserved.[19] Upon receiving a COA, a provider may request the release of entrance fees held in escrow.[20]

Pursuant to s. 651.028, F.S., if a provider is accredited by a process found by the OIR to be acceptable and substantially equivalent to the provisions of ch. 651, F.S., the OIR may, pursuant to rule of the commission, waive any requirements of ch. 651, F.S., with respect to the provider if the OIR finds that such waivers are not inconsistent with the security protections of ch. 651, F.S.

[9] OFFICE OF INSURANCE REGULATION, *Specialty Product Administration*, http://www.floir.com/Sections/Specialty/is_sp_index.aspx (last visited February 6, 2015).
[10] Part I, ch. 631, F.S. is the Insurers Rehabilitation and Liquidation Act.
[11] ss. 631.031 and 651.114(6), F.S. *Administrative supervision* allows DFS to supervise the management of a consenting troubled insurance company in an attempt to cure the company's troubles rather than close it down. In *rehabilitation*, DFS is authorized as receiver to conduct all business of the insurer in an attempt to place the insurance company back in sound financial condition. In *liquidation*, DFS is authorized as receiver to gather the insurance company's assets, convert them to cash, distribute them to various claimants, and shut down the company.
[12] s. 651.011(2), F.S., defines continuing care as "furnishing shelter or nursing care or personal services to a resident who resides in a facility, whether such nursing care or personal services are provided in the facility or in another setting designated in the contract for continuing care, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee."
[13] s. 651.011(9), F.S.
[14] s. 651.022, F.S.; *see also* s. 651.022(2) and (3), F.S., for detailed description of information, reports and studies required to be submitted with an application for a provisional COA.
[15] s. 651.022(5) and (6), F.S.
[16] s. 651.022(7), F.S., which requires the fee to be deposited into escrow or placed in deposit with DFS, until a COA is issued by OIR.
[17] s. 651.023(1), F.S.
[18] s. 651.023(4), F.S.
[19] s. 651.023(4)(a), F.S.
[20] s. 651.023(6), F.S.

CCC Contracts

Continuing care services are governed by a contract between the facility and the resident of a CCC. In Florida, continuing care contracts are considered a kind of specialty insurance product, and are reviewed and approved for the market by the OIR.[21] Each contract for continuing care services must:

- Provide for continuing care of one resident, or two residents living in a double occupancy room, under regulations established by the provider;
- List all properties transferred to the facility and their market value at the time of transfer;
- Specify all services to be provided to each resident;
- Describe terms and conditions for cancellation of the contract;
- Describe the health and financial conditions required for a person to be accepted as a resident and to continue as a resident;
- Describe the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident; and
- Provide the fees that will be charged if the resident marries while at the designated facility, the terms concerning the entry of a spouse to the facility, and the consequences if the spouse does not meet the requirements for entry.[22]

The contract is also required to provide that it may be canceled by giving at least 30 days' written notice by the provider, the resident, or the person who provided the transfer of property or funds for the care of such resident.[23]

In the event of receivership or liquidation proceedings against a provider, all continuing care contracts executed by a provider must be deemed preferred claims against all assets owned by the provider.[24]

Entrance Fee Refunds

A resident of a CCC is required to pay an entrance fee upon entering a contract with a facility, which does not secure the resident an ownership interest in the CCC unit, but allows the resident to occupy the unit and to access the CCC's services. According to CCC providers, entrance fees can range from $100,000 to $1 million,[25] and vary according to local housing markets, geographic location, and the level of service and amenities of the CCC.[26] In addition to the entrance fee, CCRCs charge *monthly fees* which typically cover housing costs, amenities, meals, and health care. The pricing of a CCRC's entrance fees and monthly fees is typically accomplished through actuarial analysis.[27]

Traditionally, these entrance fees were non-refundable, amortizing over 4 years. However, due to growing demand from residents and their estates, several CCRCs allow for partial or full refunds with declining-scale features.[28] Current law requires that the contract include the terms for which a resident is due a refund of any portion of the entrance fee.[29] If the contract provides that the resident does not

---

[21] s. 651.055(1), F.S.
[22] Id.
[23] s. 651.055(1)(g), F.S.
[24] s. 651.071, F.S.
[25] AMERICAN ASSOCIATION FOR RETIRED PERSONS, *About Continuing Care Communities*, http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/ho_continuing_care_retirement_communities.html (last viewed Mar. 12, 2015).
[26] U.S. GOV'T ACCOUNTABILITY OFFICE, *Older Americans: Continuing Care Retirement Communities Can Provide Benefits, but Not Without Some Risk* (GAO-10-611) (June 2010), *available at* http://www.gao.gov/new.items/d10611.pdf.
[27] Kelly Greene, *Continuing-Care Retirement Communities: Weighing the Risks*, THE WALL STREET JOURNAL (Aug. 7, 2010), http://www.wsj.com/articles/SB10001424052748704499604575407290112356422 (citing the National Investment Center for the Seniors Housing and Care Industry).
[28] See footnote 1, at p. 8.
[29] s. 651.055(1)(g), F.S.

receive a transferable membership or ownership right in the facility, and the resident has occupied his or her unit, the refund must be calculated on a pro-rata basis with the facility retaining up to two-percent per month of occupancy by the resident and up to a five-percent processing fee, the balance of which must be paid within 120 days after the resident gives notice of intent to cancel. This is known as a two-percent declining-scale refund and provides a resident with up to 47.5 months of residency before the refund is reduced to zero. Similarly, a contract may provide a one-percent declining-scale refund and is allowed to have the timing of any resident refund dependent on the resale of any unit but are not allowed to make the timing dependent on the resale of a particular unit or type of units.[30]

When a CCC files for bankruptcy, residents may be considered unsecured creditors, which receive lower priority than secured creditors and can thus lose part or all of their entrance fees. In bankruptcy, the debtor CCC has the ability to reject "executory contracts," including life-care contracts with its residents, pursuant to §365 of the federal Bankruptcy Code.[31] Additionally, the residents' interests are usually subordinate to the CCRC's secured creditors as well as most of its other unsecured creditors, leaving the residents with little to no recovered portion of their entrance fees.

Resident Rights and Residents' Council

Section 651.081, F.S., provides for the creation of a single statewide residents' council. Section 651.085, F.S., requires the governing body of a provider, or the designated representative of the provider, to hold quarterly meetings with the residents of the CCC for the purpose of free discussion of issues and concerns of residents, as well as the facility's financial condition and potential fee increases. The residents' council is tasked with different duties associated with the quarterly meetings between residents and the governing body of the provider, as provided in s. 651.085, F.S.

References to the residents' council in s. 651.085, F.S., may be confused or misinterpreted to allow for multiple councils instead of the singular council as created by s. 651.081, F.S. Currently, it is optional to both establish a residents' council and to do so through the election process outlined in statute.

Examinations and Inspections

The OIR is authorized to examine at any time, and at least once every three years, the business of any applicant for a certificate of authority and any provider engaged in the execution of care contracts in the same manner as provided for the examination of insurance companies[32] pursuant to s. 624.316, F.S.[33] The OIR is required to notify the provider in writing of all deficiencies in its compliance with the provisions of ch. 651, F.S., and must set a reasonable length of time for compliance by the provider.[34] At the time of routine examination, OIR must determine if all disclosures required under ch. 651, F.S., have been made to the president or chair of the residents' council. According to the OIR, the OIR gives a copy of its examination findings to a member of the CCC's management (typically, the executive director). However, these findings are not always shared with the CCC's board of directors, so that the board is unaware of regulatory issues.[35]

---

[30] Id.

[31] 11 U.S.C. §365(a). A bankruptcy trustee's ability to reject executory contracts

[32] s. 624.316, F.S., "...The office shall examine the affairs, transactions, accounts, records, and assets of each authorized insurer and of the attorney in fact of a reciprocal insurer as to its transactions affecting the insurer as often as it deems advisable, except as provided in this section. The examination may include examination of the affairs, transactions, accounts, and records relating directly or indirectly to the insurer and of the assets of the insurer's managing general agents and controlling or controlled person, as defined in s. 625.012. The examination shall be pursuant to a written order of the office. Such order shall expire upon receipt by the office of the written report of the examination."

[33] s. 651.105(1), F.S.

[34] s. 651.105(4), F.S.

[35] Office of Insurance Regulation, Agency Analysis of House Bill 749, p. 2 (Mar. 2, 2015).

Effect of Proposed Changes

Refunds of Entrance Fees for Cancelled CCC Contracts

The bill amends s. 651.055, F.S., to modify the timing of refunds paid by CCCs to their residents for certain contracts. A CCC contract, paying a two-percent declining-scale refund, must provide for payment to a resident within 90 days after the contract is terminated and the unit is vacated, instead of 120 days after notice of intent to cancel as required by current law. Similarly, the bill requires a CCC contract, paying a one-percent declining-scale refund, to provide for payment to a resident from:

- The proceeds of the next entrance fees received by the provider for units for which there are no prior claims by any resident;
- The proceeds of the next entrance fee received by the provider for a like or similar unit as specified in the residency or reservation contract signed by the resident for which there are no prior claims by any resident until paid in full; or
- The proceeds of the next entrance fee received by the provider for the unit that is vacated if the contract is approved by the OIR before October 1, 2015. Providers may not use this refund option after October 1, 2016, and must submit a new or amended contract with an alternative refund provision to the office for approval by August 2, 2016.

For contracts entered into on or after January 1, 2016, that provide for a refund from the proceeds of the next entrance fee received by the provider for a like or similar unit, the bill requires any refund that is due upon the resident's death or relocation of the resident to another level of care that results in the termination of the contract to be paid the earlier of:

- Thirty days after receipt by the provider of the next entrance fee received for a like or similar unit for which there is no prior claim by any resident until paid in full; or
- No later than a specified maximum number of months or years, determined by the provider and specified in the contract, after the contract is terminated and the unit is vacated.

Further, the bill requires any refund that is due to be paid to a resident who vacates the unit and voluntarily terminates a contract after the seven-day rescission period, to be paid within thirty days of receipt by the provider of the next entrance fee for a like or similar unit for which there are no prior claims. A contract is voluntarily terminated when a resident provides written notice of intent to leave and moves out of the CCC after the seven-day rescission period. The bill defines the term "like or similar units" to mean a residential dwelling categorized into a group of units which have similar characteristics such as comparable square footage, number of bedrooms, location, age of construction, or a combination of one or more of these features. A CCC that offers such contracts must have a minimum of the lesser of five-percent of the total number of independent living units or ten units in each category unless the category consists of single family home, in which case there is no limit.

Notice of Examination Report and Corrective Action Report; Disclosure of Audit

The bill amends s. 651.105, F.S., to require the OIR to notify the executive office of the governing body of the CCC provider about all deficiencies found as part of an examination, and requires a CCC to provide a copy of any final examination report and corrective action plan to the executive officer of the governing body of the provider within 60 days after issuance of the report.

Residents' Councils and Quarterly Meetings

The bill amends s. 651.081, F.S., to require each CCC to establish a residents' council to provide a forum for residents' input on subjects that impact the general residential quality of life, and requires that the council must be established through an election by the residents. The bill provides mandatory attributes of a residents' council. Residents' council activities must be independent of the CCRC provider. Additionally, the CCRC provider is not responsible for the costs of the residents' council or ensuring the council's compliance with statute. The residents' council must adopt its own bylaws and governance documents. The governing documents may include term limits for council members.

The council must also provide for open meetings when appropriate. The council's governing documents must define the process by which residents may submit such inquiries and issues and the timeframe for the council to respond. The council must also serve as a liaison to provide input on such matters to the appropriate representative of the CCRC.

If a licensed CCRC files for federal chapter 11 bankruptcy, the CCC must include in its required filing with the United States Trustee the 20 largest unsecured creditors, the name and contact information of a designated resident of the residents' council, and, if appropriate, a statement explaining why the designated resident was chosen by the residents' council to serve as a representative of the residents' interest on the creditors' committee.

The bill amends s. 651.085, F.S., to authorize the board of directors or governing board of a licensed provider to allow a facility resident to be a voting member of the board or governing body of the facility. The bill also amends s. 651.091, F.S., to requires all CCCs to provide a copy of the most recent third-party financial audit to the president or chair of the residents' council within 30 days of filing the annual report to OIR.

Priority of Claims in Bankruptcy, Receivership, or Liquidation

The bill amends s. 651.071, F.S., to make CCC contracts and continuing care at-home contracts preferred claim against a provider in bankruptcy proceedings (not just in receiverships and liquidations), subordinate to any secured claims.[36]

Waiver of CCC Requirements

The bill amends s. 651.028, F.S., requires that a CCC must be accredited without stipulations or conditions for the OIR to waive any statutory requirements under ch. 651, F.S.[37]

B. SECTION DIRECTORY:

Section 1: Amends s. 651.055, F.S., relating to continuing care contracts; right to rescind.
Section 2: Amends s. 651.028, F.S., relating to accredited facilities.
Section 3: Amends s. 651.071, F.S., relating to contracts as preferred claims on liquidation or receivership.
Section 4: Amends s. 651.105, F.S., relating to examination and inspections.
Section 5: Amends s. 651.081, F.S., relating to resident's council.
Section 6: Amends s. 651.085, F.S., relating to quarterly meetings between residents and the governing body of the provider; resident representation before the governing body of the provider.

---

[36] "Preferred claims" are not interests in any particular property; they are similar to priority claims in bankruptcy, which are satisfied from all assets after secured claims (including valid statutory liens) have been paid in full. *See* Nathalie D. Martin, *The Insolvent Life Care Provider: Who Leads the Dance Between the Federal Bankruptcy Code and State Continuing-Care Statutes?* 61 Ohio St. L.J. 267, 310-311 (2000).

[37] Typically, the only requirement that OIR waives is the requirement to submit quarterly reports. OIR Analysis, p. 2.

Section 7: Amends s. 651.091, F.S., relating to availability, distribution, and posting of reports and records; requirement of full disclosure.
Section 8: Provides an effective date of October 1, 2015.

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 have a positive private sector by providing clearer processes to refund entrance fees to residents and improving disclosures between CCCs and their residents.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   Section 3 of the bill amends s. 651.071, F.S., to treat CCC contracts as preferred claims in federal bankruptcy, although subject to any secured claim. However, Article I, §8, clause 4 of the U.S. Constitution empowers Congress to establish uniform laws on the subject of bankruptcies throughout the United States. Under the Supremacy Clause of the U.S. Constitution, the Bankruptcy Code supersedes all state laws in the area of bankruptcy.[38]

   Courts have held that any state law that conflicts with the provisions or purposes of the Bankruptcy Code is preempted by it, unless the state law protects the health and welfare of its citizens. Other than in the areas of criminal law and environmental law, courts have consistently protected

[38] U.S. Const. art. VI, §2.

bankruptcy rights over virtually all state statutes that conflict (either directly or indirectly) with the Bankruptcy Code.[39]

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[39] *See* footnote 36, at pp. 284-285.

1 A bill to be entitled
2 An act relating to continuing care communities;
3 amending s. 651.055, F.S.; revising requirements for
4 continuing care contracts; amending s. 651.028, F.S.;
5 revising authority of the Office of Insurance
6 Regulation to waive requirements for accredited
7 facilities; amending s. 651.071, F.S.; providing that
8 continuing care and continuing care at-home contracts
9 are preferred claims in the event of bankruptcy
10 proceedings against a provider; revising subordination
11 of claims; amending s. 651.105, F.S.; revising notice
12 requirements; revising duties of the office; requiring
13 an agent of a provider to provide a copy of an
14 examination report and corrective action plan under
15 certain conditions; amending s. 651.081, F.S.;
16 requiring a residents' council to provide a forum for
17 certain purposes; requiring a residents' council to
18 adopt its own bylaws and governance documents;
19 amending s. 651.085, F.S.; revising provisions
20 relating to quarterly meetings between residents and
21 the governing body of the provider; revising powers of
22 the residents' council; amending s. 651.091, F.S.;
23 revising continuing care facility reporting
24 requirements; providing an effective date.
25
26 Be It Enacted by the Legislature of the State of Florida:

27

28 Section 1. Paragraphs (g) through (k) of subsection (1) of
29 section 651.055, Florida Statutes, are amended to read:
30 651.055 Continuing care contracts; right to rescind.—
31 (1) Each continuing care contract and each addendum to
32 such contract shall be submitted to and approved by the office
33 before its use in this state. Thereafter, no other form of
34 contract shall be used by the provider until it has been
35 submitted to and approved by the office. Each contract must:
36 (g) Provide that the contract may be canceled by giving at
37 least 30 days' written notice of cancellation by the provider,
38 the resident, or the person who provided the transfer of
39 property or funds for the care of such resident. However, if a
40 contract is canceled because there has been a good faith
41 determination that a resident is a danger to himself or herself
42 or others, only such notice as is reasonable under the
43 circumstances is required.
44 (h)~~1.~~ Describe ~~The contract must also provide~~ in clear and
45 understandable language, in print no smaller than the largest
46 type used in the body of the contract, the terms governing the
47 refund of any portion of the entrance fee.
48 1.~~2.~~ For a resident whose contract with the facility
49 provides that the resident does not receive a transferable
50 membership or ownership right in the facility, and who has
51 occupied his or her unit, the refund shall be calculated on a
52 pro rata basis with the facility retaining up to 2 percent per

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

53 month of occupancy by the resident and up to a 5 percent
54 processing fee. Such refund must be paid within 120 days after
55 giving the notice of intention to cancel. For contracts entered
56 into on or after January 1, 2016, refunds must be made within 90
57 days after the contract is terminated and the unit is vacated. A
58 resident who enters into a contract before January 1, 2016, may
59 voluntarily sign a contract addendum approved by the office that
60 provides for such revised refund requirement.
61 2.~~3.~~ In addition to a processing fee not to exceed 5
62 percent, if the contract provides for the facility to retain no
63 more than ~~up to~~ 1 percent per month of occupancy by the resident
64 and the resident does not receive a transferable membership or
65 ownership right in the facility, the contract shall~~, it may~~
66 provide that such refund will be paid from one of the following:
67 a. The proceeds of the next entrance fees received by the
68 provider for units for which there are no prior claims by any
69 resident until paid in full;
70 b. The proceeds of the next entrance fee received by the
71 provider for a like or similar unit as specified in the
72 residency or reservation contract signed by the resident for
73 which there are no prior claims by any resident until paid in
74 full; or
75 c. The proceeds of the next entrance fee received by the
76 provider for the unit that is vacated if the contract is
77 approved by the office before October 1, 2015. Providers may not
78 use this refund option after October 1, 2016, and must submit a

79 new or amended contract with an alternative refund provision to
80 the office for approval by August 2, 2016~~, if the provider has~~
81 ~~discontinued marketing continuing care contracts, within 200~~
82 ~~days after the date of notice~~.
83 3. For contracts entered into on or after January 1, 2016,
84 that provide for a refund in accordance with sub-subparagraph
85 2.b., the following provisions apply:
86 a. Any refund that is due upon the resident's death or
87 relocation of the resident to another level of care that results
88 in the termination of the contract must be paid the earlier of:
89 (I) Thirty days after receipt by the provider of the next
90 entrance fee received for a like or similar unit for which there
91 is no prior claim by any resident until paid in full; or
92 (II) No later than a specified maximum number of months or
93 years, determined by the provider and specified in the contract,
94 after the contract is terminated and the unit is vacated.
95 b. Any refund that is due to a resident who vacates the
96 unit and voluntarily terminates a contract after the 7-day
97 rescission period required in subsection (2) must be paid within
98 30 days after receipt by the provider of the next entrance fee
99 for a like or similar unit for which there are no prior claims
100 by any resident until paid in full and is not subject to the
101 provisions in sub-subparagraph a. A contract is voluntarily
102 terminated when a resident provides written notice of intent to
103 leave and moves out of the continuing care facility after the 7-
104 day rescission period.

105 4. For purposes of this paragraph, the term "like or
106 similar unit" means a residential dwelling categorized into a
107 group of units which have similar characteristics such as
108 comparable square footage, number of bedrooms, location, age of
109 construction, or a combination of one or more of these features
110 as specified in the residency or reservation contract. Each
111 category must consist of at least 5 percent of the total number
112 of residential units designated for independent living or 10
113 residential units designated for independent living, whichever
114 is less. However, a group of units consisting of single family
115 homes may contain fewer than 10 units.
116 5. If the provider has discontinued marketing continuing
117 care contracts, any refund due a resident must be paid within
118 200 days after the contract is terminated and the unit is
119 vacated.
120 6.~~4.~~ Unless subsection (5) applies, for any prospective
121 resident, regardless of whether or not such a resident receives
122 a transferable membership or ownership right in the facility,
123 who cancels the contract before occupancy of the unit, the
124 entire amount paid toward the entrance fee shall be refunded,
125 less a processing fee of up to 5 percent of the entire entrance
126 fee; however, the processing fee may not exceed the amount paid
127 by the prospective resident. Such refund must be paid within 60
128 days after the resident gives ~~giving~~ notice of intention to
129 cancel. For a resident who has occupied his or her unit and who
130 has received a transferable membership or ownership right in the

131 facility, the foregoing refund provisions do not apply but are
132 deemed satisfied by the acquisition or receipt of a transferable
133 membership or an ownership right in the facility. The provider
134 may not charge any fee for the transfer of membership or sale of
135 an ownership right.
136 (i) ~~(h)~~ State the terms under which a contract is canceled
137 by the death of the resident. These terms may contain a
138 provision that, upon the death of a resident, the entrance fee
139 of such resident is considered earned and becomes the property
140 of the provider. If the unit is shared, the conditions with
141 respect to the effect of the death or removal of one of the
142 residents must be included in the contract.
143 (j) ~~(i)~~ Describe the policies that may lead to changes in
144 monthly recurring and nonrecurring charges or fees for goods and
145 services received. The contract must provide for advance notice
146 to the resident, of at least 60 days, before any change in fees
147 or charges or the scope of care or services is effective, except
148 for changes required by state or federal assistance programs.
149 (k) ~~(j)~~ Provide that charges for care paid in one lump sum
150 may not be increased or changed during the duration of the
151 agreed upon care, except for changes required by state or
152 federal assistance programs.
153 (l) ~~(k)~~ Specify whether the facility is, or is affiliated
154 with, a religious, nonprofit, or proprietary organization or
155 management entity; the extent to which the affiliate
156 organization will be responsible for the financial and

157 contractual obligations of the provider; and the provisions of
158 the federal Internal Revenue Code, if any, under which the
159 provider or affiliate is exempt from the payment of federal
160 income tax.
161 Section 2. Section 651.028, Florida Statutes, is amended
162 to read:
163 651.028 Accredited facilities.—If a provider is accredited
164 without stipulations or conditions by a process found by the
165 office to be acceptable and substantially equivalent to the
166 provisions of this chapter, the office may, pursuant to rule of
167 the commission, waive any requirements of this chapter with
168 respect to the provider if the office finds that such waivers
169 are not inconsistent with the security protections intended by
170 this chapter.
171 Section 3. Subsection (1) of section 651.071, Florida
172 Statutes, is amended to read:
173 651.071 Contracts as preferred claims on liquidation or
174 receivership.—
175 (1) In the event of bankruptcy, receivership or
176 liquidation proceedings against a provider, all continuing care
177 and continuing care at-home contracts executed by a provider
178 shall be deemed preferred claims against all assets owned by the
179 provider; however, such claims are subordinate to ~~those priority~~
180 ~~claims set forth in s. 631.271 and~~ any secured claim.
181 Section 4. Subsections (4) and (5) of section 651.105,
182 Florida Statutes, are amended, and subsection (6) is added to

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

183 that section, to read:
184 651.105 Examination and inspections.—
185 (4) The office shall notify the provider and the executive
186 officer of the governing body of the provider in writing of all
187 deficiencies in its compliance with the provisions of this
188 chapter and the rules adopted pursuant to this chapter and shall
189 set a reasonable length of time for compliance by the provider.
190 In addition, the office shall require corrective action or
191 request a corrective action plan from the provider which plan
192 demonstrates a good faith attempt to remedy the deficiencies by
193 a specified date. If the provider fails to comply within the
194 established length of time, the office may initiate action
195 against the provider in accordance with the provisions of this
196 chapter.
197 (5) At the time of the routine examination, the office
198 shall determine if all disclosures required under this chapter
199 have been made to the president or chair of the residents'
200 council and the executive officer of the governing body of the
201 provider.
202 (6) A representative of the provider must give a copy of
203 the final examination report and corrective action plan, if one
204 is required by the office, to the executive officer of the
205 governing body of the provider within 60 days after issuance of
206 the report.
207 Section 5. Section 651.081, Florida Statutes, is amended
208 to read:

209 651.081 Residents' council.—
210 (1) Residents living in a facility holding a valid
211 certificate of authority under this chapter have the right of
212 self-organization, the right to be represented by an individual
213 of their own choosing, and the right to engage in concerted
214 activities for the purpose of keeping informed on the operation
215 of the facility that is caring for them or for the purpose of
216 other mutual aid or protection.
217 (2)(a) Each facility shall establish a residents' council
218 created for the purpose of representing residents on matters set
219 forth in s. 651.085. The residents' council shall ~~may~~ be
220 established through an election in which the residents, as
221 defined in s. 651.011, vote by ballot, physically or by proxy.
222 If the election is to be held during a meeting, a notice of the
223 organizational meeting must be provided to all residents of the
224 community at least 10 business days before the meeting. Notice
225 may be given through internal mailboxes, communitywide
226 newsletters, bulletin boards, in-house television stations, and
227 other similar means of communication. An election creating a
228 residents' council is valid if at least 40 percent of the total
229 resident population participates in the election and a majority
230 of the participants vote affirmatively for the council. The
231 initial residents' council created under this section is valid
232 for at least 12 months. A residents' organization formalized by
233 bylaws and elected officials must be recognized as the
234 residents' council under this section and s. 651.085. Within 30

235 days after the election of a newly elected president or chair of
236 the residents' council, the provider shall give the president or
237 chair a copy of this chapter and rules adopted thereunder, or
238 direct him or her to the appropriate public website to obtain
239 this information. Only one residents' council may represent
240 residents before the governing body of the provider as described
241 in s. 651.085(2).
242 (b) In addition to those matters provided in s. 651.085, a
243 residents' council shall provide a forum in which a resident may
244 submit issues or make inquiries related to, but not limited to,
245 subjects that impact the general residential quality of life and
246 cultural environment. The residents' council shall serve as a
247 formal liaison to provide input related to such matters to the
248 appropriate representative of the provider.
249 (c) The activities of a residents' council are independent
250 of the provider. The provider is not responsible for ensuring,
251 or for the associated costs of, compliance of the residents'
252 council with the provisions of this section with respect to the
253 operation of a resident's council.
254 (d) A residents' council shall adopt its own bylaws and
255 governance documents. The residents' council shall provide for
256 open meetings when appropriate. The governing documents shall
257 define the manner in which residents may submit an issue to the
258 council and define a reasonable timeframe in which the
259 residents' council shall respond to a resident submission or
260 inquiry. A residents' council may include term limits in its

261 governing documents to ensure consistent integration of new
262 leaders. If a licensed facility files for bankruptcy under
263 chapter 11 of the United States Bankruptcy Code, 11 U.S.C.
264 chapter 11, the facility, in its required filing of the 20
265 largest unsecured creditors with the United States Trustee,
266 shall include the name and contact information of a designated
267 resident selected by the residents' council, and a statement
268 explaining that the designated resident was chosen by the
269 residents' council to serve as a representative of the
270 residents' interest on the creditors' committee, if appropriate.
271 Section 6. Section 651.085, Florida Statutes, is amended
272 to read:
273 651.085 Quarterly meetings between residents and the
274 governing body of the provider; resident representation before
275 the governing body of the provider.—
276 (1) The governing body of a provider, or the designated
277 representative of the provider, shall hold quarterly meetings
278 with the residents of the continuing care facility for the
279 purpose of free discussion of subjects including, but not
280 limited to, income, expenditures, and financial trends and
281 problems as they apply to the facility, as well as a discussion
282 on proposed changes in policies, programs, and services. At
283 quarterly meetings where monthly maintenance fee increases are
284 discussed, a summary of the reasons for raising the fee as
285 specified in subsection (4) must be provided in writing to the
286 president or chair of the residents' council. Upon request of

287 the residents' council, a member of the governing body of the
288 provider, such as a board member, general partner, principal
289 owner, or designated representative shall attend such meetings.
290 Residents are entitled to at least 7 days' advance notice of
291 each quarterly meeting. An agenda and any materials that will be
292 distributed by the governing body or representative of the
293 provider shall be posted in a conspicuous place at the facility
294 and shall be available upon request to residents of the
295 facility. The office shall request verification from a facility
296 that quarterly meetings are held and open to all residents ~~if it~~
297 ~~receives a complaint from the residents' council that a facility~~
298 ~~is not in compliance with this subsection~~. In addition, a
299 facility shall report to the office in the annual report
300 required under s. 651.026 the dates on which quarterly meetings
301 were held during the reporting period.
302 (2) A residents' council formed pursuant to s. 651.081,
303 members of which are elected by the residents, shall ~~may~~
304 designate a resident to represent them before the governing body
305 of the provider o~~r organize a meeting or ballot election of the~~
306 ~~residents to determine whether to elect a resident to represent~~
307 ~~them before the governing body of the provider. If a residents'~~
308 ~~council does not exist, any resident may organize a meeting or~~
309 ~~ballot election of the residents of the facility to determine~~
310 ~~whether to elect a resident to represent them before the~~
311 ~~governing body and, if applicable, elect the representative. The~~
312 ~~residents' council, or the resident that organizes a meeting or~~

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

313 ~~ballot election to elect a representative, shall give all~~
314 ~~residents notice at least 10 business days before the meeting or~~
315 ~~election. Notice may be given through internal mailboxes,~~
316 ~~communitywide newsletters, bulletin boards, in-house television~~
317 ~~stations, and other similar means of communication. An election~~
318 ~~of the representative is valid if at least 40 percent of the~~
319 ~~total resident population participates in the election and a~~
320 ~~majority of the participants vote affirmatively for the~~
321 ~~representative.~~ The initial designated representative elected
322 under this section shall be elected to serve at least 12 months.
323 (3) The designated representative shall be notified at
324 least 14 days in advance of any meeting of the full governing
325 body at which proposed changes in resident fees or services will
326 be discussed. The representative shall be invited to attend and
327 participate in that portion of the meeting designated for the
328 discussion of such changes.
329 (4) At a quarterly meeting prior to the implementation of
330 any increase in the monthly maintenance fee, the designated
331 representative of the provider must provide the reasons, by
332 department cost centers, for any increase in the fee that
333 exceeds the most recently published Consumer Price Index for All
334 Urban Consumers, all items, Class A Areas of the Southern
335 Region. Nothing in this subsection shall be construed as placing
336 a cap or limitation on the amount of any increase in the monthly
337 maintenance fee, establishing a presumption of the
338 appropriateness of the Consumer Price Index as the basis for any

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

339 increase in the monthly maintenance fee, or limiting or
340 restricting the right of a provider to establish or set monthly
341 maintenance fee increases.
342 (5) The board of directors or governing board of a
343 licensed provider may at its sole discretion allow a resident of
344 the facility to be a voting member of the board or governing
345 body of the facility. The board of directors or governing board
346 of a licensed provider may establish specific criteria for the
347 nomination, selection, and term of a resident as a member of the
348 board or governing body. If the board or governing body of a
349 licensed provider operates more than one licensed facility,
350 regardless of whether the facility is in-state or out-of-state,
351 the board or governing body may select at its sole discretion
352 one resident from among its facilities to serve on the board of
353 directors or governing body on a rotating basis.
354 Section 7. Paragraph (d) of subsection (2) of section
355 651.091, Florida Statutes, is amended to read:
356 651.091 Availability, distribution, and posting of reports
357 and records; requirement of full disclosure.—
358 (2) Every continuing care facility shall:
359 (d) Distribute a copy of the full annual statement and a
360 copy of the most recent third party financial audit filed with
361 the annual report to the president or chair of the residents'
362 council within 30 days after filing the annual report with the
363 office, and designate a staff person to provide explanation
364 thereof.

365 Section 8. This act shall take effect October 1, 2015.

INSURANCE & BANKING SUBCOMMITTEE

HB 749 by Rep. Van Zant
Continuing Care Communities

AMENDMENT SUMMARY
March 18, 2015

Amendment 1 by Rep. Van Zant (line 175): Provides that the treatment of continuing care contracts as preferred claims applies only in receivership and liquidation proceedings, not in bankruptcy proceedings.

Amendment 2 by Rep. Van Zant (line 255): Clarifies that a residents' council shall adopt its own bylaws and governance documents subject to the residents' vote and approval.

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	____	

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Van Zant offered the following:
4
5 **Amendment 1 (with title amendment)**
6 Remove line 175 and insert:
7 (1) In the event of receivership or
8
9 ---
10 **T I T L E A M E N D M E N T**
11 Remove lines 9-10 and insert:
12 are preferred claims subject to any secured claim in the event
13 of liquidation or receivership proceedings against a provider;
14 revising subordination

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 749 (2015)

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	____	

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Van Zant offered the following:
4
5 **Amendment 2**
6 Remove line 255 and insert:
7 governance documents subject to the vote and approval of the
8 residents. The residents' council shall provide for

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1025 Firesafety for Agricultural Buildings
SPONSOR(S): Raburn and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1148

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

SUMMARY ANALYSIS

The Florida Fire Prevention Code (FFPC) contains all firesafety laws and rules that pertain to public and private buildings, structures, and facilities and the enforcement of such firesafety laws and rules. It is adopted by rule, pursuant to ch. 120, F.S., by the State Fire Marshal.

Under current law, a structure located on property that is classified as agricultural, is exempt from the FFPC if the occupancy is limited by the property owner to no more than 35 persons. Tents up to 30 feet by 30 feet are also exempted from the FFPC, including the national codes. The local fire officials are required to fashion reasonable alternatives that afford an equivalent degree of lifesafety and safety of property if it is not practical to apply any or all of the provisions of the FFPC.

This bill exempts agricultural pole barns, which are nonresidential farm buildings in which 90 percent or more of the perimeter walls are permanently open, from the FFPC without restrictions. It also exempts certain other nonresidential farm buildings from the FFPC if the building is used by the owner for assembly, business, or mercantile occupancy, no more than 20 times per year, and each occupancy lasts no longer than 72 hours and has no more than 150 persons in attendance.

The bill requires the State Fire Marshal to conduct a study on the secondary use of nonresidential farm buildings as assembly occupancies that are used more than 20 times per year or have more than 150 persons in attendance. The State Fire Marshal must convene a workgroup for this study and determine if assembly occupancy requires life safety and fire prevention standards that are different from those currently contained in the FFPC and to initiate rulemaking to facilitate the use of such alternatives in farm outbuildings.

The bill revises the exemption of tents from the FFPC from up to 30 feet by 30 feet to up to 900 square feet. The bill also allows local fire officials to consider the Fire Safety Evaluation System as an acceptable source in identifying reasonable alternatives to current standards under s. 633.208, F.S.

The bill has minimal to no fiscal impact on state government.

The bill should have a minimal negative fiscal impact to local governments associated with the collection of fines for violations of the FFPC. However, this impact may be offset by a minimal positive fiscal impact on local government associated with decreased costs for inspections of certain nonresidential farm buildings covered by the bill.

The bill should have a minimal positive fiscal impact on the private sector associated with decreased fines for violations of the FFPC by certain nonresidential farm buildings covered by the bill.

The bill has an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

The Chief Financial Officer is designated as the "State Fire Marshal." The State Fire Marshal is charged with enforcing the provisions of ch. 633, F.S., and all other applicable laws relating to firesafety and has the responsibility to minimize the loss of life and property in this state due to fire.[1]

The Florida Fire Prevention Code (FFPC) contains all firesafety laws and rules that pertain to the design, construction, erection, alteration, modification, repair, and demolition of public and private buildings, structures, and facilities and the enforcement of such firesafety laws and rules. It is adopted by rule, pursuant to ch. 120, F.S., by the State Fire Marshal. The State Fire Marshal adopts a new edition of the FFPC every third year.[2]

Under current law, a structure located on property that is classified as agricultural, which is part of a farming or ranching operation, is exempt from the FFPC, including the national codes and Life Safety Code, if the occupancy is limited by the property owner to no more than 35 persons and is not used by the public for direct sales or as an educational outreach facility. Current law also exempts tents up to 30 feet by 30 feet from the FFPC, including the national codes.[3]

Also, since the legislature recognizes that it is not always practical to apply any or all of the provisions of the FFPC, under the minimum firesafety standards, the local fire officials shall apply the applicable firesafety code for existing buildings to the extent practical to ensure a reasonable degree of lifesafety and safety of property. The local fire officials are also required to fashion reasonable alternatives that afford an equivalent degree of lifesafety and safety of property.

Effect of Bill

The bill exempts agricultural pole barns, which are nonresidential farm buildings in which 90 percent or more of the perimeter walls are permanently open, from the FFPC without restrictions. It also revises the description of structures currently exempt from the FFPC in which the occupancy is limited by the property owner to no more than 35 persons, to nonresidential farm buildings.

This bill also exempts certain other nonresidential farm buildings from the FFPC if the building is used by the owner for assembly, business, or mercantile occupancy, no more than 20 times per year. Business occupancy is defined by the National Fire Protection Association as an occupancy used for account and record keeping, or the transaction of business other than mercantile. Mercantile occupancy is defined as an occupancy used for the display and sale of merchandise. Additionally, under the new exemption created by the bill, each occupancy may last no longer than 72 hours and have no more than 150 persons in attendance.

The bill requires the State Fire Marshal to conduct a study on the secondary use of nonresidential farm buildings as assembly occupancies that are used more than 20 times per year or have more than 150 persons in attendance. The State Fire Marshal must convene a workgroup, consisting of various stakeholders including the Department of Agriculture and Consumer Services, for this study and determine if assembly occupancy requires life safety and fire prevention standards that are different from those currently contained in the FFPC and to initiate rulemaking to facilitate the use of such alternatives in farm outbuildings.

[1] s. 633.104, F.S.
[2] s. 633.202, F.S.
[3] s. 633.202(16), F.S.

The bill revises the exemption of tents from the FFPC from up to 30 feet by 30 feet to up to 900 square feet. The bill also allows local fire officials to consider the Fire Safety Evaluation System as an acceptable source in identifying reasonable alternatives to current standards under s. 633.208, F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 633.202, F.S., relating to exemptions from the Florida Fire Prevention Code.

Section 2: Amends s. 633.208, F.S., relating to the minimum fire safety standards and alternatives to the firesafety code.

Section 3: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Uncertain. The Department of Agriculture and Consumers Services believes that participation in the workgroup and rulemaking process will have minimal to no fiscal impact on the department as they anticipate using current staff and resources

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   Uncertain. Minimal negative fiscal impact on local governments, equal to positive impact on private sector, associated with decreased collection of fines for violations of the FFPC due to exemption of certain nonresidential farm buildings covered by the bill.

2. Expenditures:

   Uncertain. Minimal positive fiscal impact on local governments associated with decreased cost of inspections of nonresidential farming buildings covered by the bill.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Uncertain. Minimal positive fiscal impact on the private sector associated with decreased fines for violations of the FFPC due to exemption of certain nonresidential farm buildings covered by the bill.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The FFPC is currently adopted by rule, therefore the State Fire Marshall may already engage in rulemaking to create alternative standards to the FFPC under s. 633.202(9), F.S., without recommendations from a workgroup.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The new exemption added by the bill for nonresidential farm buildings used for mercantile occupancy if the occupancy has no more than 150 person in attendance conflicts with the current exemption where occupancy is limited by the property owner to no more than 35 persons and the structure is not used by the public for direct sales. Because direct sales is a form of mercantile occupancy and the bill creates an exemption from the FFPC for mercantile occupancy, the bill has the effect of eliminating the restriction on direct sales at nonresidential farm buildings with up to 35 persons.

Additionally, the bill limits exemption for occupancies of no more than 150 persons. The bill does not refer to a building's maximum occupancy loads. Although a building may be exempt with an occupancy of up to 150 persons under this bill, the maximum occupancy load under the National Fire Protection Code may require that the exempt nonresidential farm building decrease the maximum number of persons in attendance below 150 persons, based on the size of the building.

The sponsor has indicated he will be filing an amendment to address these issues.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to firesafety for agricultural
3 buildings; amending s. 633.202, F.S.; providing
4 definitions; exempting certain nonresidential farm
5 buildings from the Florida Fire Prevention Code under
6 specified circumstances; requiring the State Fire
7 Marshal to conduct a study addressing secondary uses
8 of certain nonresidential farm outbuildings; requiring
9 the State Fire Marshal to convene a workgroup by a
10 specified date to assist with the study; requiring the
11 State Fire Marshal to initiate rulemaking by a
12 specified date if the study determines that
13 alternative life safety or fire prevention standards
14 are required; amending s. 633.208, F.S.; authorizing
15 local fire officials to consider specific chapters of
16 the Florida Fire Prevention Code to find alternative
17 low-cost reasonable options for firesafety for certain
18 buildings; providing an effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Subsection (16) of section 633.202, Florida
23 Statutes, is amended to read:
24 633.202 Florida Fire Prevention Code.—
25 (16)(a) As used in this subsection, the term:
26 1. "Agricultural pole barn" means a nonresidential farm

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

27 building in which 90 percent of more of the perimeter walls are
28 permanently open and allow free ingress and egress.
29 2. "Nonresidential farm building" has the same meaning as
30 provided in s. 604.50.
31 (b) A nonresidential farm building as defined in s.
32 604.50(2) structure, located on property that is classified for
33 ad valorem purposes as agricultural, which is part of a farming
34 or ranching operation, in which the occupancy is limited by the
35 property owner to no more than 35 persons, and which is not used
36 by the public for direct sales or as an educational outreach
37 facility, is exempt from the Florida Fire Prevention Code,
38 including the national codes and Life Safety Code incorporated
39 by reference. This paragraph does not include structures used
40 for residential or assembly occupancies, as defined in the
41 Florida Fire Prevention Code.
42 (c) Notwithstanding any other provision of law, a
43 nonresidential farm building as defined in s. 604.50(2) is
44 exempt from the Florida Fire Prevention Code, including the
45 national codes and the Life Safety Code incorporated by
46 reference, if:
47 1. The nonresidential farm building is used by the owner
48 for assembly, business, or mercantile occupancy, as defined in
49 the Florida Fire Prevention Code, no more than 20 times per
50 year.
51 2. Each occupancy lasts no longer than 72 hours and has no
52 more than 150 persons in attendance.

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

53 (d) Notwithstanding any other provision of law, an
54 agricultural pole barn is exempt from the Florida Fire
55 Prevention Code, including the national fire codes and the Life
56 Safety Code incorporated by reference.
57 (e) The State Fire Marshal shall conduct a study on the
58 secondary use of nonresidential farm buildings as assembly
59 occupancies that are used more than 20 times per year or have
60 more than 150 persons in attendance.
61 1. The State Fire Marshal shall convene a workgroup no
62 later than September 1, 2015, to assist with the study, which
63 shall include representatives of the Florida Agritourism
64 Association, the Florida Farm Bureau, the Florida Department of
65 Agriculture and Consumer Services, the Florida Fire Chiefs'
66 Association, the Florida Professional Firefighters, the Florida
67 Fire Marshals and Inspectors Association, the Florida State
68 Firefighters' Association, the Florida Volunteer Fire Officers'
69 Association, and other interested parties.
70 2. If the study determines that an assembly occupancy
71 described under this paragraph requires life safety and fire
72 prevention standards that are different from those currently
73 contained in the Florida Fire Prevention Code, the State Fire
74 Marshal shall initiate rulemaking pursuant to ss. 120.536(1) and
75 120.54 by December 1, 2015, to facilitate the use of such
76 alternatives in farm outbuildings used on a secondary basis as
77 assembly occupancies.
78 (17)~~(b)~~ A tent up to 900 square ~~30 feet by 30~~ feet is

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

79 exempt from the Florida Fire Prevention Code, including the
80 national codes incorporated by reference.
81 Section 2. Subsection (5) of section 633.208, Florida
82 Statutes, is amended to read:
83 633.208 Minimum firesafety standards.—
84 (5) With regard to existing buildings, the Legislature
85 recognizes that it is not always practical to apply any or all
86 of the provisions of the Florida Fire Prevention Code and that
87 physical limitations may require disproportionate effort or
88 expense with little increase in fire or life safety. Before
89 ~~Prior to~~ applying the minimum firesafety code to an existing
90 building, the local fire official shall determine that a threat
91 to lifesafety or property exists. If a threat to lifesafety or
92 property exists, the fire official shall apply the applicable
93 firesafety code for existing buildings to the extent practical
94 to ensure ~~assure~~ a reasonable degree of lifesafety and safety of
95 property or the fire official shall fashion a reasonable
96 alternative that ~~which~~ affords an equivalent degree of
97 lifesafety and safety of property. The local fire official may
98 consider the firesafety evaluation system found in the current
99 edition of the National Fire Protection Association, "NFPA 101A:
100 Guide on Alternative Solutions to Life Safety" as adopted by the
101 State Fire Marshal, to identify acceptable low-cost
102 alternatives. The decision of the local fire official may be
103 appealed to the local administrative board described in s.
104 553.73.

105 Section 3. This act shall take effect July 1, 2015.

INSURANCE & BANKING SUBCOMMITTEE

HB 1025 by Rep. Raburn
Firesafety for Agricultural Buildings

AMENDMENT SUMMARY
March 18, 2015

Amendment 1 by Rep. Raburn (lines 26-52): Makes the following changes:

- Removes the current limitation on direct sales for exemptions of agricultural structures.
- Requires the property owner to notify the local fire official of each occupancy at least 7 days before the occupancy.
- Clarifies that the nonresidential farm building may not be used for lodging purposes.
- Clarifies that the <u>only</u> secondary uses exempt from the Florida Fire Prevention Code under the bill are assembly, business, and mercantile occupancy.
- Clarifies that each occupancy may last no longer than 72 <u>consecutive</u> hours.
- Clarifies that each occupancy may have no more than 150 persons in attendance <u>at one time</u>.
- Provides that the exempt nonresidential farm building must have at least two exits of a certain size.
- Provides that the exempt nonresidential farm building must provide at least 7 square feet per person in attendance if the building is unconcentrated with chairs and tables and 15 square feet per person if the building is concentrated with chairs and tables.
- Provides that the storage of combustible or flammable liquids in the nonresidential farm building is not permitted during an occupancy.
- Removes language requiring the State Fire Marshal to convene a workgroup, conduct a study, and initiate rulemaking.

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	____	

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Raburn offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 26-77 and insert:
7 1. "Agricultural pole barn" means a nonresidential farm
8 building in which 90 percent or more of the perimeter walls are
9 permanently open and allow free ingress and egress.
10 2. "Nonresidential farm building" has the same meaning as
11 provided in s. 604.50.
12 (b) A nonresidential farm building as defined in s.
13 604.50(2) ~~structure, located on property that is classified for~~
14 ~~ad valorem purposes as agricultural, which is part of a farming~~
15 ~~or ranching operation~~, in which the occupancy is limited by the
16 property owner to no more than 35 persons, and which is not used
17 by the public ~~for direct sales or~~ as an educational outreach

18 facility, is exempt from the Florida Fire Prevention Code,
19 including the national codes and Life Safety Code incorporated
20 by reference. ~~This paragraph does not include structures used~~
21 ~~for residential or assembly occupancies, as defined in the~~
22 ~~Florida Fire Prevention Code.~~
23 (c) Notwithstanding any other provision of law, a
24 nonresidential farm building as defined in s. 604.50(2) is
25 exempt from the Florida Fire Prevention Code, including the
26 national codes and the Life Safety Code incorporated by
27 reference, if all of the following are met:
28 1. The owner of the property shall notify the local fire
29 official of each occupancy that meets the conditions of this
30 section at least 7 days before the occupancy. The local fire
31 official shall not require a filing fee for the notification.
32 2. The nonresidential farm building is used by the owner
33 only for the following secondary purposes: assembly, business,
34 or mercantile occupancy, as defined in the Florida Fire
35 Prevention Code, no more than 20 times per year and is not used
36 for lodging purposes.
37 3. Each occupancy lasts no longer than 72 consecutive hours
38 and has no more than 150 persons in attendance at one time as
39 limited by the property owner.
40 4. There shall be at least two means of egress or openings
41 of at least 36″ in width and 6′8″ in height which shall open in
42 the direction of the exit travel.

43 5. The nonresidential farm building provides at least 7
44 square feet per person in attendance if the building is
45 unconcentrated with chairs, tables, or other obstacles and 15
46 square feet per person in attendance if the building is
47 concentrated with chairs, tables, or other obstacles.
48 6. The storage of combustible or flammable liquids inside
49 the nonresidential farm building during each occupancy shall not
50 be permitted.
51 (d) Notwithstanding any other provision of law, an
52 agricultural pole barn is exempt from the Florida Fire
53 Prevention Code, including the national fire codes and the Life
54 Safety Code incorporated by reference.
55
56 ---
57 **T I T L E A M E N D M E N T**
58 Remove lines 6-14 and insert:
59 specified circumstances; amending s. 633.208, F.S.; authorizing

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1053 Motor Vehicle Insurance
SPONSOR(S): Fant
TIED BILLS: **IDEN./SIM. BILLS:** SB 1250

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

SUMMARY ANALYSIS

Private passenger motor vehicle insurance is written to individuals, and family members in the same household, for coverage of automobiles that are not used for commercial purposes. The bill includes the following changes:

Electronic Delivery/Signature of Uninsured Motorist Insurance Waivers – Uninsured Motorist (UM) coverage protects motorists against injuries caused by owners or operators of uninsured or underinsured motor vehicles. The law requires insurers who offer bodily injury liability coverage also to offer UM coverage in the same amount as any policy limits applying to the bodily injury liability policy. However, s. 627.727, F.S., allows an insured individual to waive UM coverage, select a lower limit, or select "non-stacking" UM coverage, if the named insured signs a policy waiver form approved by the Office of Insurance Regulation. The approved form must include a heading in 12-point bold type and state, "You are electing not to purchase certain valuable coverage which protects you and your family or you are purchasing uninsured motorist limits less than your bodily injury liability limits when you sign this form. Please read carefully." The bill allows the required form to be presented to and signed by the insured electronically. The required header statement will be larger than the surrounding text when the waiver form is provided electronically.

Personal Injury Protection (PIP) Insurance – Florida's Motor Vehicle No-Fault Law (the "No-Fault Law") requires motorists to carry at least $10,000 of no-fault insurance, known as personal injury protection (PIP) coverage. The purpose of the No-Fault Law is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents. Payments for PIP related medical services utilize the Medicare fee schedule in effect on March 1 of the year the service is rendered. The fee schedule in effect on March 1 applies for the remainder of that year; it is unclear what period "remainder of that year" describes (e.g., the calendar year or until the following March 1); the bill provides that the fee schedule applies until the last day of February of the following year.

Preinsurance Inspection of Private Passenger Motor Vehicles – Under current law, motor vehicle insurers are required to conduct preinsurance motor vehicle inspections. There are exemptions from the preinsurance inspections for "purchased" cars, if certain documents are provided The bill adds leased vehicles to the specified exemptions; allows insurers to elect to receive the documents, rather than requiring their delivery; revises the types of documents that insurers may require; and, limits claim reimbursement and property damage coverage suspension based on the timing of document delivery.

The bill has no fiscal impact on state or local government expenditures. The bill should have a positive impact on the private sector. The bill is effective July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Private passenger motor vehicle insurance is casualty coverage[1] within the personal lines[2] segment of insurance business. Insurers issue it to individuals, or related individuals in the same household, for coverage of private passenger automobiles that are not used as public conveyances, for rental to others, or in the occupation, profession, or business of the insured (excluding farm business use).[3] Commercial motor vehicles are those that are not private passenger motor vehicles.[4]

Electronic Delivery/Signature of Uninsured Motorist Insurance Waivers

Uninsured Motorist (UM) coverage protects insureds against injuries caused by owners or operators of uninsured or underinsured motor vehicles. The law requires insurers who offer bodily injury liability coverage also to offer UM coverage in the same amount as any policy limits applying to the bodily injury liability policy.[5]

Conventional UM insurance is "stackable." This means that if one family member purchases one UM policy for one vehicle, that coverage extends to every resident and every vehicle in the household, whether or not those residents or vehicles are covered by their own UM policies. Moreover, if a family purchases UM coverage for multiple vehicles, any resident in the household may "stack" the UM benefits and recover the combined policy limits from each insured vehicle.

However, s. 627.727, F.S., allows an insured individual to waive this insurance, select a lower limit, or select "non-stacking" UM coverage if the named insured signs a policy waiver form approved by the Office of Insurance Regulation (OIR). The approved form must include a heading in 12-point bold type stating, "You are electing not to purchase certain valuable coverage which protects you and your family or you are purchasing uninsured motorist limits less than your bodily injury liability limits when you sign this form. Please read carefully."[6]

The Federal Electronic Signatures in Global and National Commerce Act (E-SIGN) applies to electronic transactions involving interstate commerce.[7] Insurance is specifically included in E-SIGN.[8] E-SIGN provides contracts formed using electronic signatures on electronic records will not be denied legal effect only because they are electronic. However, E-SIGN requires consumer disclosure and consent to electronic records in certain instances before electronic records will be given legal effect. Under E-SIGN, if a statute requires information to be provided or made available to a consumer in writing, the use of an electronic record to provide or make the information available to the consumer will satisfy the statute's requirement of writing if the consumer affirmatively consents to use of an electronic record. The consumer must also be provided with a statement notifying the consumer of the right to have the electronic information made available in a paper format and of the right to withdraw consent to electronic records, among other notifications.

In addition, s. 668.50, F.S., Florida's Uniform Electronic Transaction Act (UETA), is similar to the federal E-SIGN law. UETA specifically applies to insurance and provides a requirement in statute that

---

[1] Section 627.021(3), F.S.

[2] Personal lines insurance is property and casualty insurance sold to individuals and families for non-commercial purposes. S. 626.015(15), F.S.

[3] Sections 627.041(8) and 627.728(1)(a), F.S.

[4] Section 627.732(3)(a), F.S.

[5] Section 627.727(1), F.S.

[6] Id.

[7] Section 101, Electronic Signatures in Global and National Commerce Act, Pub. L. no. 106-229, 114 Stat 464 (2000). Many of the provisions of E-SIGN took effective October 1, 2000.

[8] Id.

information that must be delivered in writing to another person can be satisfied by delivering the information electronically if the parties have agreed to conduct a transaction by electronic means.

The bill allows electronic presentation and signature of the required UM waiver form. If it is presented electronically, the required header statement must be greater in size than the surrounding text, rather than in 12-point bold.[9] The OIR has the authority to approve the form, including the electronic version, and has the obligation to ensure that the consumer has ready and reasonable access to the required notification based on the display characteristics of the electronic form being approved.

Personal Injury Protection Insurance

Florida's Motor Vehicle No-Fault Law (the "No-Fault Law")[10] requires motorists to carry at least $10,000 of no-fault insurance, known as personal injury protection (PIP) coverage. The purpose of the No-Fault Law is to provide for medical, surgical, funeral, and disability insurance benefits without regard to fault. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents. Florida motorists are required to carry a minimum of $10,000 of PIP insurance, $10,000, per person, and $20,000, per incident, of bodily injury coverage, and $10,000 of property damage liability coverage.[11,12]

PIP insurance benefits are payable as follows.

- Up to a limit of $10,000, 80 percent of reasonable medical expenses for:
  1) Initial services and care lawfully provided, supervised, ordered or prescribed by a medical doctor, osteopathic physician, chiropractic physician or that are provided in a hospital or in a facility that owns, or is wholly owned by a hospital. Initial services and care may also be provided for emergency transport and treatment.
  2) Upon referral by any of the above-listed providers, follow-up services and care consistent with the underlying medical diagnosis, which may be provided, supervised, ordered, or prescribed only by a medical doctor, osteopathic physician, chiropractic physician, or dentist, or, to the extent permitted under applicable law and under the supervision of such provider, by a physician assistant or advanced registered nurse practitioner. Follow-up services and care may also be provided by:
     a) A licensed hospital or ambulatory surgical center.
     b) An entity wholly owned[13] by a medical doctor, osteopathic physician, chiropractic physician, or by such practitioner(s) and specified family members.
     c) An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.
     d) A licensed physical therapist, based upon a referral by a provider listed in 2).
     e) A licensed health care clinic that meets specified criteria.
  3) Reimbursement for services and care pursuant to 1) or 2) of up to $10,000 if a medical doctor, osteopathic physician, dentist, physician assistant, or an advanced registered nurse practitioner determines that the injured person had an emergency medical condition.
- Up to a limit of $2,500, 80 percent of reasonable medical expenses when a provider listed in 1) or 2) determines that the injured person did not have an emergency medical condition.

---

[9] The specified point size of type is a measure of physical size on a printed page. It is related to typeface printing and the characteristics of type set text. It does not necessarily identify the physical size of the character itself. Rather, it describes a maximum height parameter within the complete font type collection. One point in physical type face is 1/72 of an inch, thus 12-point font is 12/72 of an inch. Point size does not directly translate to graphical display size in electronics. Electronic display size is measured in picture elements, popularly known as pixels. Different size displays contain different numbers of pixels. Accordingly, specifying the point size of electronic text presents challenges that can require a high degree of technical precision. See http://www.thomasphinney.com/2011/03/point-size/. (Last accessed March 13, 2015.)

[10] Sections 627.730-627.7405, F.S.

[11] Section 627.7275, F.S.

[12] Under Florida's Financial Responsibility Law (ch. 324, F.S.), motorists must also provide proof of ability to pay monetary damages for bodily injury and property damage liability at the time of motor vehicle accidents or when serious traffic violations occur.

[13] As defined in the bill, "entity wholly owned" means a proprietorship, group practice, partnership, or corporation that provides health care services rendered by licensed health care practitioners and in which licensed health care practitioners are the business owners of all aspects of the business entity. . . .

Medical benefits do not include massages or acupuncture, regardless of the provider that performs the service. Massage therapists and acupuncturists are not eligible for reimbursement under PIP.

Medical providers and entities may charge the insurer and injured party only a reasonable amount for services and care rendered. Insurers that provide reimbursement under the schedule of charges may use all Medicare coding policies and CMS payment methodologies, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care, if such coding policy or payment methodology does not constitute a utilization limit. Effective July 1, 2012, insurers that want to utilize the PIP schedule of maximum charges must amend their forms to include the schedule.

House Bill 119, the personal injury protection insurance (PIP) reform bill enacted in 2012,[14] amended s. 627.736(5)(a)2., F.S., by establishing the date on which changes to the Medicare fee schedule or payment limitation are effective. The legislation provides in part that:

> [T]he applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies, or care is rendered...*and the applicable fee schedule or payment limitation applies throughout the remainder of that year* [italics added for emphasis]. . . ."

The above-emphasized language created uncertainty as to whether the Medicare fee schedule in place on March 1st applied through the calendar year (through December 31st) or whether it applied through the end of February of the following year. On November 6, 2012, the OIR issued Informational Memorandum OIR-12-06M,[15] stating that the plain language of the section requires the fee schedule in place on March 1st to apply throughout the following 365 days, or until the following March 1st.

The bill amends s. 627.736(5)(a)2., F.S., to provide that the applicable Medicare fee schedule applies from March 1 until the last day of February the following year, rather than for the remainder of that year. The bill also removes the language from s. 627.736(5)(a)5., F.S., referencing the inception date of July 1, 2012, for insurers to being noticing their use of the Medicare fees schedule on their policies.

Preinsurance Inspection of Private Passenger Motor Vehicles

Section 627.744, F.S., requires insurers to perform preinsurance inspections of private passenger motor vehicles. It also provides various exemptions from the required preinsurance inspection, including for new, unused motor vehicles "purchased" from a licensed motor vehicle dealer or leasing company when the insurer is provided with the bill of sale, buyer's order, or copy of the title and certain other documentation.

Despite the exemptions, an insurer may require a preinsurance inspection of any motor vehicle as a condition of issuance of physical damage coverage. Physical damage coverage may not be suspended during the policy period due to the applicant's failure to provide the required documents. However, claim payments are conditioned upon and are not payable until the required documents are received by the insurer. Applicants for insurance may be required to pay the cost of the preinsurance inspection, not to exceed five dollars.

The bill adds an exemption from preinsurance inspection for new, unused "leased" motor vehicles to the existing exemption for "purchased" vehicles, if the vehicle is leased from a licensed motor vehicle dealer or leasing company. If the insurer waives its right to a preinsurance inspection, it also provides an insurer the discretion to require persons who purchase or lease a new, unused motor vehicle to submit certain documents. Currently, such documents are required to be provided whenever the exemption is utilized. Persons who do not submit the required documentation, upon request, at the time

---

[14] Ch. 2012-151, L.O.F.

[15] Available at http://www.floir.com/Sections/PandC/ProductReview/PIPInfo.aspx (last accessed: January 23, 2015).

the policy is issued are required to submit the document before any physical damage loss is payable under the policy. The bill amends the list of documents that an insurer may require to include the vehicle registration in addition to the existing option of providing the vehicle title along with the window sticker and deletes from the list of documents the detailed dealer's invoice. Failure of the insurer to request the documentation is added to the prohibition on suspending coverage due to the insured's failure to provide documentation. Finally, the condition on claim payment pending receipt of documentation is revised to apply only if the carrier exercised its option to require the documentation.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.727, F.S., relating to motor vehicle insurance; uninsured and underinsured vehicle coverage; insolvent insurer protection.

Section 2: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.

Section 3: Amends s. 627.744, F.S., relating to required preinsurance inspection of private passenger motor vehicles.

Section 4: Provides an effective date of July 1, 2015.

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 should have a positive impact on the private sector by creating savings through the use of electronic notifications and allowing the insurer to limit costs related to preinsurance inspections that they may elect to forego. The extent of this benefit has not been calculated. However, any savings realized by insurers should be passed through to policyholders.

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:

The bill amends section 627.736(5)(a)2., F.S., to provide that the applicable Medicare fee schedule applies from March 1 until the last day of February of the following year. To include the last day of February in this period, the language should be revised to have it apply from March 1 through the last day of February of the following year. Also, under the current law and the bill, it is unclear whether a medical service rendered in January or February would be reimbursed under the Medicare fee schedule from the previous March 1 or the next March 1. Addressing this point will avoid confusion over the applicable fee schedule and expected reimbursement for January and February dates of service.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to motor vehicle insurance; amending
3 s. 627.727, F.S.; authorizing insurers to
4 electronically provide a form to reject, or select
5 lower coverage amounts of, uninsured motorist vehicle
6 coverage to an insurance applicant; authorizing the
7 applicant to sign the form electronically; amending s.
8 627.736, F.S.; revising the period during which the
9 applicable fee schedule or payment limitation under
10 Medicare applies with respect to certain personal
11 injury protection insurance coverage; deleting an
12 obsolete date; amending s. 627.744, F.S.; revising the
13 exemption from the preinsurance inspection
14 requirements for private passenger motor vehicles to
15 include certain leased vehicles; revising the list of
16 documents that an insurer may require for purposes of
17 the exemption; prohibiting the physical damage
18 coverage on a motor vehicle from being suspended
19 during the term of a policy due to the insurer's
20 option not to require certain documents; authorizing a
21 payment of a claim to be conditioned if the insurer
22 requires a document under certain circumstances;
23 providing an effective date.
24
25 Be It Enacted by the Legislature of the State of Florida:
26

27 Section 1. Subsection (1) of section 627.727, Florida
28 Statutes, is amended to read:
29 627.727 Motor vehicle insurance; uninsured and
30 underinsured vehicle coverage; insolvent insurer protection.—
31 (1) A ~~No~~ motor vehicle liability insurance policy that
32 ~~which~~ provides bodily injury liability coverage may not ~~shall~~ be
33 delivered or issued for delivery in this state with respect to a
34 ~~any~~ specifically insured or identified motor vehicle registered
35 or principally garaged in this state unless uninsured motor
36 vehicle coverage is provided therein or supplemental thereto for
37 the protection of persons insured by the policy ~~thereunder~~ who
38 are legally entitled to recover damages from owners or operators
39 of uninsured motor vehicles because of bodily injury, sickness,
40 or disease, including death, resulting therefrom. However, the
41 coverage required under this section is not applicable if ~~when,~~
42 ~~or to the extent that,~~ an insured named in the policy makes a
43 written rejection of the coverage on behalf of all insureds
44 under the policy. If ~~When~~ a motor vehicle is leased for a period
45 of 1 year or longer and the lessor of the ~~such~~ vehicle, by the
46 terms of the lease contract, provides liability coverage on the
47 leased vehicle, the lessee of the ~~such~~ vehicle has ~~shall have~~
48 the sole privilege to reject uninsured motorist coverage or to
49 select lower limits than the bodily injury liability limits,
50 regardless of whether the lessor is qualified as a self-insurer
51 pursuant to s. 324.171. Unless an insured, or lessee having the
52 privilege of rejecting uninsured motorist coverage, requests

53 such coverage or requests higher uninsured motorist limits in
54 writing, the coverage or the ~~such~~ higher uninsured motorist
55 limits are ~~need~~ not required to be provided in or supplemental
56 to any other policy that ~~which~~ renews, extends, changes,
57 supersedes, or replaces an existing policy with the same bodily
58 injury liability limits when an insured or lessee had rejected
59 the coverage. If ~~When~~ an insured or lessee ~~has~~ initially
60 selected limits of uninsured motorist coverage lower than her or
61 his bodily injury liability limits, higher limits of uninsured
62 motorist coverage are ~~need~~ not required to be provided in or
63 supplemental to any other policy that ~~which~~ renews, extends,
64 changes, supersedes, or replaces an existing policy with the
65 same bodily injury liability limits unless an insured requests
66 higher uninsured motorist coverage in writing. The rejection or
67 selection of lower limits must ~~shall~~ be made on a form approved
68 by the office. The form must ~~shall~~ fully advise the applicant of
69 the nature of the coverage and must ~~shall~~ state that the
70 coverage is equal to bodily injury liability limits unless lower
71 limits are requested or the coverage is rejected. The heading of
72 the form shall be in 12-point bold type and shall state: "You
73 are electing not to purchase certain valuable coverage which
74 protects you and your family or you are purchasing uninsured
75 motorist limits less than your bodily injury liability limits
76 when you sign this form. Please read carefully." If this form is
77 signed by a named insured, it will be conclusively presumed that
78 there was an informed, knowing rejection of coverage or election

79 of lower limits on behalf of all insureds. The form may be
80 provided electronically to and may be signed electronically by
81 the applicant. If the form is provided electronically, the
82 requirement for 12-point bold type does not apply but the
83 heading of the form must be of greater size than the surrounding
84 text. The insurer must ~~shall~~ notify the named insured at least
85 annually of her or his options as to the coverage required by
86 this section. Such notice must ~~shall~~ be part of, and attached
87 to, the notice of premium, must ~~shall~~ provide for a means to
88 allow the insured to request such coverage, and must ~~shall~~ be
89 given in a manner approved by the office. Receipt of this notice
90 does not constitute an affirmative waiver of the insured's right
91 to uninsured motorist coverage where the insured has not signed
92 a selection or rejection form. The coverage described under this
93 section must ~~shall~~ be over and above, but may ~~shall~~ not
94 duplicate, the benefits available to an insured under any
95 workers' compensation law, personal injury protection benefits,
96 disability benefits law, or similar law; under any automobile
97 medical expense coverage; under any motor vehicle liability
98 insurance coverage; or from the owner or operator of the
99 uninsured motor vehicle or any other person or organization
100 jointly or severally liable together with such owner or operator
101 for the accident; and such coverage must ~~shall~~ cover the
102 difference, if any, between the sum of such benefits and the
103 damages sustained, up to the maximum amount of such coverage
104 provided under this section. The amount of coverage available

105 under this section may ~~shall~~ not be reduced by a setoff against
106 any coverage, including liability insurance. Such coverage may
107 ~~shall~~ not inure directly or indirectly to the benefit of a ~~any~~
108 workers' compensation or disability benefits carrier or a ~~any~~
109 person or organization qualifying as a self-insurer under a ~~any~~
110 workers' compensation or disability benefits law or similar law.
111 Section 2. Paragraph (a) of subsection (5) of section
112 627.736, Florida Statutes, is amended to read:
113 627.736 Required personal injury protection benefits;
114 exclusions; priority; claims.—
115 (5) CHARGES FOR TREATMENT OF INJURED PERSONS.—
116 (a) A physician, hospital, clinic, or other person or
117 institution lawfully rendering treatment to an injured person
118 for a bodily injury covered by personal injury protection
119 insurance may charge the insurer and injured party only a
120 reasonable amount pursuant to this section for the services and
121 supplies rendered, and the insurer providing such coverage may
122 pay for such charges directly to such person or institution
123 lawfully rendering such treatment if the insured receiving such
124 treatment or his or her guardian has countersigned the properly
125 completed invoice, bill, or claim form approved by the office
126 upon which such charges are to be paid for as having actually
127 been rendered, to the best knowledge of the insured or his or
128 her guardian. However, such a charge may not exceed the amount
129 the person or institution customarily charges for like services
130 or supplies. In determining whether a charge for a particular

131 service, treatment, or otherwise is reasonable, consideration
132 may be given to evidence of usual and customary charges and
133 payments accepted by the provider involved in the dispute,
134 reimbursement levels in the community and various federal and
135 state medical fee schedules applicable to motor vehicle and
136 other insurance coverages, and other information relevant to the
137 reasonableness of the reimbursement for the service, treatment,
138 or supply.
139 1. The insurer may limit reimbursement to 80 percent of
140 the following schedule of maximum charges:
141 a. For emergency transport and treatment by providers
142 licensed under chapter 401, 200 percent of Medicare.
143 b. For emergency services and care provided by a hospital
144 licensed under chapter 395, 75 percent of the hospital's usual
145 and customary charges.
146 c. For emergency services and care as defined by s.
147 395.002 provided in a facility licensed under chapter 395
148 rendered by a physician or dentist, and related hospital
149 inpatient services rendered by a physician or dentist, the usual
150 and customary charges in the community.
151 d. For hospital inpatient services, other than emergency
152 services and care, 200 percent of the Medicare Part A
153 prospective payment applicable to the specific hospital
154 providing the inpatient services.
155 e. For hospital outpatient services, other than emergency
156 services and care, 200 percent of the Medicare Part A Ambulatory

157 Payment Classification for the specific hospital providing the
158 outpatient services.
159 f. For all other medical services, supplies, and care, 200
160 percent of the allowable amount under:
161 (I) The participating physicians fee schedule of Medicare
162 Part B, except as provided in sub-sub-subparagraphs (II) and
163 (III).
164 (II) Medicare Part B, in the case of services, supplies,
165 and care provided by ambulatory surgical centers and clinical
166 laboratories.
167 (III) The Durable Medical Equipment Prosthetics/Orthotics
168 and Supplies fee schedule of Medicare Part B, in the case of
169 durable medical equipment.
170
171 However, if such services, supplies, or care is not reimbursable
172 under Medicare Part B, as provided in this sub-subparagraph, the
173 insurer may limit reimbursement to 80 percent of the maximum
174 reimbursable allowance under workers' compensation, as
175 determined under s. 440.13 and rules adopted thereunder which
176 are in effect at the time such services, supplies, or care is
177 provided. Services, supplies, or care that is not reimbursable
178 under Medicare or workers' compensation is not required to be
179 reimbursed by the insurer.
180 2. For purposes of subparagraph 1., the applicable fee
181 schedule or payment limitation under Medicare is the fee
182 schedule or payment limitation in effect on March 1 of the year

183 in which the services, supplies, or care is rendered and for the
184 area in which such services, supplies, or care is rendered, and
185 the applicable fee schedule or payment limitation applies from
186 March 1 until the last day of February ~~throughout the remainder~~
187 of the following ~~that~~ year, notwithstanding any subsequent
188 change made to the fee schedule or payment limitation, except
189 that it may not be less than the allowable amount under the
190 applicable schedule of Medicare Part B for 2007 for medical
191 services, supplies, and care subject to Medicare Part B.
192 3. Subparagraph 1. does not allow the insurer to apply any
193 limitation on the number of treatments or other utilization
194 limits that apply under Medicare or workers' compensation. An
195 insurer that applies the allowable payment limitations of
196 subparagraph 1. must reimburse a provider who lawfully provided
197 care or treatment under the scope of his or her license,
198 regardless of whether such provider is entitled to reimbursement
199 under Medicare due to restrictions or limitations on the types
200 or discipline of health care providers who may be reimbursed for
201 particular procedures or procedure codes. However, subparagraph
202 1. does not prohibit an insurer from using the Medicare coding
203 policies and payment methodologies of the federal Centers for
204 Medicare and Medicaid Services, including applicable modifiers,
205 to determine the appropriate amount of reimbursement for medical
206 services, supplies, or care if the coding policy or payment
207 methodology does not constitute a utilization limit.
208 4. If an insurer limits payment as authorized by

209 subparagraph 1., the person providing such services, supplies,
210 or care may not bill or attempt to collect from the insured any
211 amount in excess of such limits, except for amounts that are not
212 covered by the insured's personal injury protection coverage due
213 to the coinsurance amount or maximum policy limits.
214 5. ~~Effective July 1, 2012,~~ An insurer may limit payment as
215 authorized by this paragraph only if the insurance policy
216 includes a notice at the time of issuance or renewal that the
217 insurer may limit payment pursuant to the schedule of charges
218 specified in this paragraph. A policy form approved by the
219 office satisfies this requirement. If a provider submits a
220 charge for an amount less than the amount allowed under
221 subparagraph 1., the insurer may pay the amount of the charge
222 submitted.
223 Section 3. Paragraphs (a) and (b) of subsection (2) of
224 section 627.744, Florida Statutes, are amended to read:
225 627.744 Required preinsurance inspection of private
226 passenger motor vehicles.—
227 (2) This section does not apply:
228 (a) To a policy for a policyholder who has been insured
229 for 2 years or longer, without interruption, under a private
230 passenger motor vehicle policy that ~~which~~ provides physical
231 damage coverage for any vehicle, if the agent of the insurer
232 verifies the previous coverage.
233 (b) To a new, unused motor vehicle purchased or leased
234 from a licensed motor vehicle dealer or leasing company. ~~, if~~ The

235 insurer may require ~~is provided with~~:
236 1. A bill of sale, ~~or~~ buyer's order, or lease agreement
237 that ~~which~~ contains a full description of the motor vehicle~~,~~
238 ~~including all options and accessories~~; or
239 2. A copy of the title or registration that ~~which~~
240 establishes transfer of ownership from the dealer or leasing
241 company to the customer and a copy of the window sticker ~~or the~~
242 ~~dealer invoice showing the itemized options and equipment and~~
243 ~~the total retail price of the vehicle~~.
244
245 For the purposes of this paragraph, the physical damage coverage
246 on the motor vehicle may not be suspended during the term of the
247 policy due to the applicant's failure to provide or the
248 insurer's option not to require the required documents. However,
249 if the insurer requires a document under this paragraph at the
250 time the policy is issued, payment of a claim may be ~~is~~
251 conditioned upon the receipt by the insurer of the required
252 documents, and no physical damage loss occurring after the
253 effective date of the coverage is payable until the documents
254 are provided to the insurer.
255 Section 4. This act shall take effect July 1, 2015.

Insurance & Banking Subcommittee

HB 1053 by Rep. Fant
Motor Vehicle Insurance

AMENDMENT SUMMARY
March 18, 2015

Amendment 1 by Rep. Fant (Line 180): The amendment revises a provision to provide that the applicable Medicare schedule in effect on March 1 would apply to PIP medical services, supplies, and care rendered from March 1 through the end of February of the following year and to provide a definition of "service year" to facilitate reimbursements

.

Amendment 2 by Rep. Santiago (Line 26): The amendment adds a new section to the bill revising s. 627.311, F.S., related to the Automotive Joint Underwriters Association (Auto JUA), to allow the Auto JUA to cancel personal or commercial motor vehicle policies in the first 60 days of coverage, in certain circumstances, and to prohibit the insured from cancelling the coverage within the first 90 days, except in certain circumstances.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1053 (2015)

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	______	

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Fant offered the following:
4
5 **Amendment**
6 Remove lines 180-191 and insert:
7 2. For purposes of subparagraph 1., the applicable fee
8 schedule or payment limitation under Medicare is the fee
9 schedule or payment limitation in effect on March 1 of the
10 service year in which the services, supplies, or care is
11 rendered and for the area in which such services, supplies, or
12 care is rendered, and the applicable fee schedule or payment
13 limitation applies to services, supplies, or care rendered
14 during ~~throughout the remainder of~~ that service year,
15 notwithstanding any subsequent change made to the fee schedule
16 or payment limitation, except that it may not be less than the
17 allowable amount under the applicable schedule of Medicare Part

18 B for 2007 for medical services, supplies, and care subject to
19 Medicare Part B. For purposes of this subparagraph, the term
20 "service year" means the period from March 1 through the end of
21 February of the following year.
22

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1053 (2015)

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		

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Santiago offered the following:
4
5 **Amendment (with title amendment)**
6 Between lines 26 and 27, insert:
7 Section 1. Paragraph (m) is added to subsection (3) of
8 section 627.311, Florida Statutes, to read:
9 627.311 Joint underwriters and joint reinsurers; public
10 records and public meetings exemptions.—
11 (3) The office may, after consultation with insurers
12 licensed to write automobile insurance in this state, approve a
13 joint underwriting plan for purposes of equitable apportionment
14 or sharing among insurers of automobile liability insurance and
15 other motor vehicle insurance, as an alternate to the plan
16 required in s. 627.351(1). All insurers authorized to write
17 automobile insurance in this state shall subscribe to the plan

18 and participate therein. The plan shall be subject to continuous
19 review by the office which may at any time disapprove the entire
20 plan or any part thereof if it determines that conditions have
21 changed since prior approval and that in view of the purposes of
22 the plan changes are warranted. Any disapproval by the office
23 shall be subject to the provisions of chapter 120. The Florida
24 Automobile Joint Underwriting Association is created under the
25 plan. The plan and the association:
26 (m) May cancel personal lines or commercial policies
27 issued by the plan within the first 60 days after the effective
28 date of the policy or binder for nonpayment of premium if the
29 reason for cancellation is the issuance of a check for the
30 premium that is dishonored for any reason or any other type of
31 premium payment that is rejected or deemed invalid. An insured
32 may not cancel a policy or binder within the first 90 days, or
33 within a lesser period as required by the plan, after the
34 effective date of the policy or binder, except:
35 1. Upon total destruction of the insured motor vehicle;
36 2. Upon transfer of ownership of the insured motor
37 vehicle; or
38 3. After purchase of another policy or binder covering the
39 motor vehicle that was covered under the policy being canceled.
40
41 ---
42 **T I T L E A M E N D M E N T**
43 Between lines 2 and 3, insert:

44 s. 627.311, F.S.; authorizing a joint underwriting
45 plan and the Florida Automobile Joint Underwriting
46 Association to cancel certain insurance policies
47 within a specified period under certain circumstances;
48 prohibiting an insured from canceling certain
49 insurance policies within a specified period;
50 providing exceptions; amending

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1133 Division of Insurance Agent and Agency Services
SPONSOR(S): Fant
TIED BILLS: **IDEN./SIM. BILLS:** SB 1222

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

SUMMARY ANALYSIS

The Department of Financial Services is the state agency responsible for regulation and licensure of insurance agents and agencies. The bill amends the insurance agent and agency licensure laws. The following changes are among the major provisions of the bill, which include:

- removing the general lines agent's limitation to only sell health insurance when that health insurance is from an insurer that the agent represents for property and casualty insurance. An agent can now transact health insurance with any health insurer under the agent's general lines license.
- reducing the number of lines that the agent in charge must be licensed to transact. The agent in charge is required to be licensed in at least two of the location's lines, rather than all of the location's lines, except that if the location only handles one line, the agent in charge must be licensed in that line of insurance.
- eliminating the examination for customer representative licensing. Applicants for such licensure will qualify if they have achieved certain specified professional designations or a qualifying academic degree within 4 years prior to application.
- allowing the general lines agent, personal lines agent, and all-lines adjuster license applicants an exemption from the required examination, upon certain conditions, including obtaining certain professional designations or a qualifying academic degree.
- removing any examination exemption limitations from license transferees from other states.
- allowing non-resident agent applicants to receive an examination exemption if they hold a comparable license in another state with similar examination requirements.
- requiring attendees to complete 75 percent of course hours in required prelicensure courses for applicants to receive credit. This replaces a rule requirement that was repealed for lack of rulemaking authority.
- revising various knowledge, experience, or instruction requirements applicable to applicants for licensure as a general lines agent, personal lines agent, life agent, health agent, or all-lines adjuster.
- establishing a mandatory five year records retention requirement for insurance agents following expiration of the policy.
- eliminating a required form concerning the information notice required prior to agent recommended annuity surrender, while revising, but maintaining, statutory notice criteria.
- removing or revises various terminologies to adjust to current usage in the insurance industry.
- deleting references to correspondence courses to allow instruction through a greater variety of methods.

The bill does not impact state or local government revenues or expenditures. The bill has an indeterminate positive impact on the private sector.

The bill is effective July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

General Lines Agent
A general lines agent[1] is one who sells the following lines of insurance: property;[2] casualty,[3] including commercial liability insurance underwritten by a risk retention group, a commercial self-insurance fund,[4] or a workers' compensation self-insurance fund;[5] surety;[6] health;[7] and, marine.[8] The general lines agent may only transact health insurance for a property and casualty insurer that the general lines agent represents. If the general lines agent wishes to represent health insurers that are not also property and casualty insurers, they must be licensed as a health insurance agent.[9]

The bill removes the general lines agent's limitation to only sell health insurance under their general lines license when that health insurance is from an insurer that the agent represents for property and casualty insurance. An agent can transact health insurance under the agent's general lines license with any health insurer that appoints them for this purpose.

Agent in Charge
In 2014, HB 633[10] created s. 626.0428(4), F.S., defining the term "agent in charge"[11] and establishing the agent in charge's role, duties, and accountability. An insurance agency[12] must designate an agent in charge for each location where it conducts business.[13] An agency may designate the same agent in charge for multiple locations. The agency must file with the Department of Financial Services (DFS) the name and license number of the agent in charge and physical location of the place(s) of business that the designated agent in charge will have the responsibility for overseeing. With proper notice to the DFS, the agency can change its designation at will. If an agency has not designated an agent in charge for a location, or comes to lack such a designated agent, the location cannot conduct business until this condition is corrected. The agent in charge is responsible for violations of the Insurance Code[14] committed by licensees, agents, and any person under their supervision.[15]

An agent in charge must be licensed for each line of insurance that the particular location of the agency handles.[16] Prior to the 2014 law change, the agent in charge was not required to maintain a license in every line that the location was handling. The DFS reports that this requirement has proven unrealistic and unnecessary. The bill reduces the number of lines that the agent in charge must be licensed to

[1] Section 626.015(5), F.S.
[2] Section 624.604, F.S.
[3] Section 624.605, F.S.
[4] As defined in s. 624.462, F.S.
[5] Pursuant to s. 624.4621, F.S.
[6] Section 626.606, F.S.
[7] Sections 624.603 and 627.6482, F.S.
[8] Section 624.607, F.S.
[9] Section 626.829, F.S.
[10] Chapter No. 2014-123, L.O.F.
[11] An "agent in charge" is the licensed and appointed agent who is responsible for the supervision of all individuals within an insurance agency location, regardless of whether the agent in charge handles a specific transaction or deals with the general public in the solicitation or negotiation of insurance contracts or the collection or accounting of moneys. Section 626.0428(4)(d), F.S.
[12] "Insurance agency" means a business location at which an individual, firm, partnership, corporation, association, or other entity, other than an employee of the individual, firm, partnership, corporation, association, or other entity and other than an insurer as defined by s. 624.03 or an adjuster as defined by subsection (1), engages in any activity or employs individuals to engage in any activity which by law may be performed only by a licensed insurance agent. Section 626.015(8), F.S.
[13] Section 626.0428(4), F.S.
[14] Chapters 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code." Section 624.01, F.S.
[15] An agent in charge is only criminally liable for violations occurring under their supervision if they personally committed the act or knew or should have known of the act and related facts amounting to a violation of Ch. 626, F.S. Section 626.0428(4)(e), F.S.
[16] Section 626.0428(4)(a), F.S.

transact in order to qualify for the designation. The agent in charge is required to be licensed in at least two of the location's lines, except that if the location only handles one line, the agent in charge must be licensed in that line of insurance. The bill results in a larger number of insurance agents eligible to fulfill the agent in charge role.

Customer Representatives

The customer representative license is unique to our state. A "customer representative" is an individual appointed by a general lines agent or agency to assist that agent or agency in transacting the business of insurance from the office of that agent or agency.[17] Customer representatives are not agents.[18] They must be licensed[19] by the DFS and appointed by an insurer or employer.[20] Since this license is unique to Florida, there is no licensing reciprocity for this credential with other states.

An individual can become licensed as a customer representative upon application to the DFS either though satisfactory performance on an examination[21] or by achieving a professional designation specified in statute.[22] The following designations facilitate licensure as a customer representative without examination:

- Chartered Property and Casualty Underwriter (CPCU) from the American Institute for Property and Liability Underwriters,
- Accredited Advisor in Insurance (AAI) from the Insurance Institute of America,
- Certified Insurance Counselor (CIC) from the Society of Certified Insurance Service Counselors,
- Accredited Customer Service Representative (ACSR) from the Independent Insurance Agents of America,
- Certified Professional Service Representative (CPSR) from the National Foundation for Certified Professional Service Representatives,
- Certified Insurance Service Representative (CISR) from the Society of Certified Insurance Service Representatives, or
- Certified Insurance Representative (CIR) from the National Association of Christian Catastrophe Insurance Adjusters.

Also, an examination exemption is available to an applicant for license as a customer representative who has earned an associate degree or bachelor's degree from an accredited college or university and has completed at least 9 academic hours of property and casualty insurance curriculum, or the equivalent, or has earned one of the following the designations:

- Certified Customer Service Representative (CCSR) from the Florida Association of Insurance Agents,
- Registered Customer Service Representative (RCSR) from a regionally accredited postsecondary institution in this state, or
- Professional Customer Service Representative (PCSR) from the Professional Career Institute.

The DFS reports that 99.85 percent[23] of customer representative licenses issued in 2014 were attained by achieving one of the designations listed above.

The bill eliminates the examination for customer representative licensing. Applicants for such licensure will qualify if they have achieved the following designations within 4 years prior to application:

- from the Insurance Institute of America:
    - Accredited Advisor in Insurance (AAI),

---

[17] Section 626.015(4), F.S.
[18] Section 626.015(2), F.S.
[19] Section 626.112, F.S.
[20] Section 626.112(3), F.S. "Appointment" means the authority given by an insurer or employer to a licensee to transact insurance or adjust claims on behalf of an insurer or employer. Section 626.015(3), F.S.
[21] The scope of the examination is described in s. 626.241, F.S.
[22] Section 626.221, F.S.
[23] There were 3,979 customer representative applicants in 2014 and only 6 qualified by examination. (3,973 / 3,979 = 99.85 percent)

- Associate in General Insurance (AINS), or
- Accredited Customer Service Representative (ACSR);

- Certified Insurance Counselor (CIC) from the Society of Certified Insurance Service Counselors;
- Certified Professional Service Representative (CPSR) from the National Foundation for CPSRs;
- Certified Insurance Service Representative (CISR) from the Society of Certified Insurance Service Representatives;
- Certified Insurance Representative (CIR) from All-Lines Training;
- Professional Customer Service Representative (PCSR) from the Professional Career Institute; or
- Registered Customer Service Representative (RCSR) from a regionally accredited postsecondary institution in the state whose curriculum is approved by the department and includes comprehensive analysis of basic property and casualty lines of insurance and testing which demonstrates mastery of the subject.

The applicant can also satisfy the designation requirement with a degree from an accredited institution of higher learning, approved by the department, when the degree includes a minimum of 9 credit hours of insurance instruction, including specific instruction in the areas of property, casualty, and inland marine insurance.

The bill also corrects the names of credentialing entities specified in statute that have changed their names since they were named therein.

Exemptions from Examination

As mentioned above, an applicant may attain licensure without examination upon attainment of certain designations. This is true for applicants for life and health agents,[24] general lines agents,[25] adjusters,[26] resident or nonresident all-lines adjusters,[27] license transferees from another state,[28] and non-resident agents,[29] too. The bill allows the following license applicants to qualify for an exemption from the required examination, upon the conditions specified below:

- general lines agents, personal lines agents,[30] or all-lines adjusters who receive the CPCU designation from the American Institute for Chartered Property Casualty Underwriters.
- general lines agents or all-lines adjusters earning a degree in insurance from an accredited institution of higher learning approved by the department. Qualifying degrees must indicate a minimum of 18 credit hours of insurance instruction, including specific instruction in the areas of property, casualty, health, and commercial insurance.
- personal lines agents earning a degree from an accredited institution of higher learning approved by the department. Qualifying degrees must indicate a minimum of 9 credit hours of insurance instruction, including specific instruction in the areas of property, casualty, and inland marine insurance.

The bill removes any examination exemption limitations applicable to license transferees from other states. Also, non-resident agent applicants receive an examination exemption if they hold a comparable license in another state with similar examination requirements.

Examination Requirements

Currently, there is not a minimum course completion requirement to qualify for educational course credit. In 2014, the DFS repealed a rule, for lack of rulemaking authority, that required prelicensure

[24] Section 626.221(g), F.S.
[25] Section 626.221(h), F.S.
[26] Id.
[27] Section 626.221(j), F.S.
[28] Section 626.221(k), F.S.
[29] Section 626.211(l), F.S.
[30] "Personal lines agent" means a general lines agent who is limited to transacting business related to property and casualty insurance sold to individuals and families for noncommercial purposes. Section 626.015(15), F.S.

course attendees to complete 75 percent of the course hours to receive credit. The bill places this former rule requirement into statute. It requires attendees to complete 75 percent of course hours in required prelicensure courses for applicants to receive credit. This provides a uniform course completion standard for course providers.

Knowledge, Experience, or Instruction Requirements

General Lines Agent and Personal Line Agent Applicants

Currently, general lines agent applicants must meet specified knowledge and experience requirements within the four years preceding their application. These requirements are waived if the applicant holds the CPCU designation. The bill eliminates some requirements and revises others. The bill requires general lines agent applicants that satisfy their knowledge requirement through coursework to complete 200 aggregate hours of DFS approved coursework in the following areas of insurance: property, casualty, surety, health, and marine. These subjects are consistent with the areas that a general lines agent may transact. The DFS asserts that this conforms to current administrative requirements for coursework hours applicable to this license. The bill eliminates the option to meet this requirement by correspondence course and six-months of relevant work experience. General lines agent applicants can claim experience credit if they have 1 year of relevant experience as service representative[31] or personal lines agent.

Similarly, personal lines agent applicants must meet specified knowledge and experience requirements within the four years preceding their application. These requirements are waived if the applicant holds the CPCU designation. The bill eliminates some requirements and revises others. The bill requires personal lines agent applicants that satisfy their knowledge requirement through coursework to complete 60 aggregate hours, rather than 52 hours, of DFS approved coursework in the following areas of insurance: property, casualty, and inland marine. These subjects are consistent with the areas that a personal lines agent may transact. The bill eliminates the option to meet this requirement by correspondence course and six-months of relevant work experience. Personal lines agent applicants can claim experience credit if they have six months of relevant experience as a service representative.

Life Agent Applicants

Currently, life agent[32] applicants must meet specified knowledge and experience requirements within the four years preceding their application. These requirements are waived if the applicant holds the Chartered Life Underwriter (CLU) designation. The bill eliminates some requirements and revises others. It specifies that whoever satisfies their knowledge requirement through coursework must do so in the subjects of life insurance, annuities, and variable contracts, rather than simply insurance. A life agent applicant may satisfy their knowledge requirement by earning or maintaining one of the following designations in the four years prior to application:

- Chartered Financial Consultant (ChFC) from the American College of Financial Services
- Fellow, Life Management Institute (FLMI) from the Life Management Institute, or
- Certified Financial Planner (CFP) from the Certified Financial Planner Board of Standards.

The bill allows those applicants that rely on prior employment with the DFS or the Office of Insurance Regulation (OIR) to claim credit for their employment experience for four years following their separation from employment, rather than only 90 days.

---

[31] "Service representative" means an individual employed by an insurer or managing general agent for the purpose of assisting a general lines agent in negotiating and effecting insurance contracts when accompanied by a licensed general lines agent. A service representative shall not be simultaneously licensed as a general lines agent in this state. This subsection does not apply to life insurance. Section 626.015(17), F.S.

[32] "Life agent" means an individual representing an insurer as to life insurance and annuity contracts, or acting as a viatical settlement broker as defined in s. 626.9911, including agents appointed to transact life insurance, fixed-dollar annuity contracts, or variable contracts by the same insurer. Section 626.015(10), F.S.

Health Agent Applicants

Currently, health agent[33] applicants must meet specified knowledge and experience requirements within the four years preceding their application. These requirements are waived if the applicant holds the Chartered Life Underwriter (CLU) designation. The bill eliminates some requirements and revises others. It specifies that whoever satisfies their knowledge requirement through coursework must do so in the subject of health insurance, rather than simply insurance. A health agent applicant may satisfy their knowledge requirement by earning or maintaining one of the following designations in the four years prior to application:

- from the American College of Financial Services:
    - Registered Health Underwriter (RHU),
    - Chartered Healthcare Consultant (ChHC), or
    - Registered Employee Benefits Consultant (REBC),
- Certified Employee Benefit Specialist (CEBS) from the Wharton School of the University of Pennsylvania,
- Health Insurance Associate (HIA) from America's Health Insurance Plans, or
- Certified Financial Planner (CFP) from the Certified Financial Planner Board of Standards.

The bill allows those applicants that rely on prior employment with the DFS or the OIR to claim credit for their employment experience for four years following their separation from employment, rather than only 90 days.

All-Lines Adjuster Applicants

The bill creates for the first time, knowledge, experience, and instruction requirements for all-lines adjuster applicants as a prerequisite to examination and licensure. All-lines adjuster applicants, which are not exempted by holding the CPCU designation, shall provide the following proof of knowledge, experience, and instruction obtained within four years prior to application:

- 40 hours of DFS approved coursework in adjusting all insurance lines, except life,
- earning or maintaining an active designation as an:
    - Accredited Claims Adjuster (ACA) from a regionally accredited postsecondary institution in the state,
    - Associate in Claims (AIC) from the Insurance Institute of America,
    - Professional Claims Adjuster (PCA) from the Professional Career Institute,
    - Professional Property Insurance Adjuster (PPIA) from the HurriClaim Training Academy,
    - Certified Adjuster (CA) from All-Lines Training, or
    - Certified Claims Adjuster (CCA) from AE21 Incorporated,
- 1 year full-time work experience in specified relevant areas of insurance activities, or
- 1 year full-time insurance regulatory employment experience with the DFS or the OIR.

Retention of Records by Agents

Currently, there is no records retention requirement applicable to insurance agents. The bill requires agents to retain records for at least five years following policy expiration.

Recommendations to Surrender Annuities

Under current law, an insurance agent or insurance agency (if no agent is involved), including persons performing agent activities under a licensing exemption, is required to provide certain information to persons surrendering an annuity (i.e., cashing out an annuity) on the recommendation of the agent or agency. The law applies if the agent or agency is not recommending that the annuity proceeds be used to purchase another annuity or a life insurance policy. Upon the occurrence of these conditions, the required information notice must be provided to the annuity owner before the annuity is surrendered.

[33] "Health agent" means an agent representing a health maintenance organization or, as to health insurance only, an insurer transacting health insurance. Section 626.015(6), F.S.

The agent must disclose information including the amount of the surrender charge, the loss of minimum interest rate guarantees, the tax consequences, the amount of the forfeited death benefit, and the value of any other investment performance guarantees that result from the surrender of the annuity. This information is required to be presented on a form that meets informational standards established by rule.

The bill eliminates DFS rulemaking authority concerning the content of the form used to deliver the required information. The required notice will solely be governed by the standards specified in s. 627.4553, F.S. The bill requires the notice to be in writing, but does not remove or increase any of the elements already specified in law. The bill requires the agent to maintain a record of the notice that it delivers to the surrendering annuity owner.

Miscellaneous

The bill:

- strikes a defunct term from s. 626.2817, F.S., which regulates educational courses and providers.
- eliminates a DFS prescribed affidavit form. Interested parties will now provide an attestation in the format of their choosing.
- deletes out of date educational course subject matter requirements.[34]
- removes references to correspondence courses that currently satisfy knowledge requirements so that various methods of course delivery may be used for these purposes.
- revises the provision allowing the collection of the exact amount of a credit card facility fee to make the provision applicable without regard to any other provision of law. This is out of the apparent concern that the prohibition in s. 501.0117, F.S., on collecting a surcharge for accepting payment by credit card is a limitation on an agent's authority to collect the credit card facility fee allowed to agents under s. 626.9541(o), F.S.
- allows electronic return receipt delivery of required insurer insolvency notices to policy holders. This required notice is triggered when an agent is unable to replace a policyholder's coverage upon the insolvency of their insurer.
- requires bail bond agent[35] applicants to complete 20 hours of specified coursework, rather than simply a course without reference to the course's length. This is in addition to the currently required minimum 120 hours of instruction in the criminal justice system.
- revises course offering requirements applicable to entities offering bail bond agent prelicensing training.
- makes various technical and grammatical changes to accommodate changes in terminologies presently used in the insurance industry.

B. SECTION DIRECTORY:

Section 1: Amends s. 626.015, F.S., relating to definitions applicable to the Licensing Procedures Law.

Section 2: Amends s. 626.0428, F.S., relating to agency personnel powers, duties, and limitations.

Section 3: Amends s. 626.221, F.S., relating to examination requirement; exemptions.

---

[34] Specifically, coursework concerning the Florida Nonprofit Multiple-Employer Welfare Arrangement Act and the Employee Retirement Income Security Act, 29 U.S.C. ss. 1001 et seq., as it relates to the provision and regulation of health insurance by employers is eliminated.

[35] "Bail bond agent" means a limited surety agent or a professional bail bond agent. "Limited surety agent" means 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. "Professional bail bond agent" means 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. Subsections 648.25(2), (5), and (7), F.S.

Section 4: Amends s. 626.241, F.S., relating to scope of examination.

Section 5: Amends s. 626.2817, F.S., relating to regulation of course providers, instructors, and school officials, and monitor groups involved in prelicensure education for insurance agents and other licensees.

Section 6: Amends s. 626.311, F.S., relating to scope of license.

Section 7: Amends s. 626.732, F.S., relating to requirement as to knowledge, experience, or instruction.

Section 8: Amends s. 626.7351, F.S., relating to qualifications for customer representative's license.

Section 9: Amends s. 626.748, F.S., relating to agent's records.

Section 10: Amends s. 626.7851, F.S., relating to requirement as to knowledge, experience, or instruction.

Section 11: Amends s. 626.8311, F.S., relating to requirement as to knowledge, experience, or instruction.

Section 12: Creates s. 626.8661, F.S., relating to requirement as to knowledge, experience, or instruction.

Section 13: Amends s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices defined.

Section 14: Amends s. 627.4553, F.S., relating to recommendations to surrender.

Section 15: Amends s. 631.341, F.S., relating to notice of insolvency to policyholders by insurer, general agent, or agent.

Section 16: Amends s. 648.355, F.S., relating to temporary limited license as limited surety agent or professional bail bond agent; pending examination.

Section 17: Amends s. 648.386, F.S., relating to qualifications for prelicensing and continuing education schools and instructors.

Section 18: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have a positive impact on insurance agents and agencies by increasing the pool of agents that qualify for agent in charge designations and facilitating the licensure of qualified applicants.

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:

The bill does not grant any new rulemaking authority. The bill eliminates DFS rulemaking authority to implement the requirements of s. 627.4553, F.S., by rule.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the Division of Insurance Agent and
3 Agency Services; amending s. 626.015, F.S.; revising
4 the definition of "general lines agent," to remove
5 certain restrictions regarding health insurance;
6 amending s. 626.0428, F.S.; revising licensure
7 requirements of certain agents in charge of an
8 agency's place of business; amending s. 626.221, F.S.;
9 revising examination requirements for applicants for a
10 license as a general lines agent, personal lines
11 agent, or all-lines adjuster; amending s. 626.241,
12 F.S.; revising the scope of license examinations for
13 agents and adjusters; amending s. 626.2817, F.S.;
14 revising requirements of certain prelicensure
15 education courses for insurance agents and other
16 licensees; amending s. 626.311, F.S.; conforming
17 provisions to changes made by the act; amending s.
18 626.732, F.S.; revising requirements relating to
19 knowledge, experience, and instruction for applicants
20 for a license as a general lines or personal lines
21 agent; amending s. 626.7351, F.S.; revising
22 qualifications for a customer representative's
23 license; amending s. 626.748, F.S.; requiring agents
24 to maintain certain records for a specified time
25 period after policy expiration; amending ss. 626.7851
26 and 626.8311, F.S.; revising requirements relating to

27 the knowledge, experience, or instruction for life
28 agents and health agents, respectively; creating s.
29 626.8661, F.S.; providing knowledge, experience, and
30 instruction requirements for an all-lines adjuster;
31 amending s. 626.9541, F.S.; providing that certain
32 provisions relating to illegal dealings in premiums
33 are applicable notwithstanding any other provision of
34 law; amending s. 627.4553, F.S.; requiring an
35 insurance agent to provide and retain certain
36 information upon surrender of an annuity or life
37 insurance policy under certain circumstances; amending
38 s. 631.341, F.S.; authorizing certain notices of
39 insolvency to be delivered to policyholders by certain
40 methods; amending s. 648.355, F.S.; revising
41 instructional requirements relating to the issuance of
42 a temporary limited license as a limited surety agent;
43 amending s. 648.386, F.S.; revising curricula
44 requirements for approval and certification as a
45 limited surety agent and professional bail bond agent
46 prelicensing school; providing an effective date.
47
48 Be It Enacted by the Legislature of the State of Florida:
49
50 Section 1. Paragraph (d) of subsection (5) of section
51 626.015, Florida Statutes, is amended to read:
52 626.015 Definitions.—As used in this part:

53 (5) "General lines agent" means an agent transacting any
54 one or more of the following kinds of insurance:
55 (d) Health insurance~~, when transacted by an insurer also~~
56 ~~represented by the same agent as to property or casualty or~~
57 ~~surety insurance~~.
58 Section 2. Paragraph (a) of subsection (4) of section
59 626.0428, Florida Statutes, is amended to read:
60 626.0428 Agency personnel powers, duties, and
61 limitations.—
62 (4)(a) Each place of business established by an agent or
63 agency, firm, corporation, or association must be in the active
64 full-time charge of a licensed and appointed agent holding the
65 required agent licenses to transact at least two of the lines of
66 insurance being handled at the location. If only one line of
67 insurance is handled at the location, the agent in charge must
68 hold the required agent license to transact that line of
69 insurance.
70 Section 3. Subsection (1) and paragraphs (g) through (l)
71 of subsection (2) of section 626.221, Florida Statutes, are
72 amended to read:
73 626.221 Examination requirement; exemptions.—
74 (1) The department shall not issue any license as agent~~,~~
75 ~~customer representative,~~ or adjuster to any individual who has
76 not qualified for, taken, and passed to the satisfaction of the
77 department a written examination of the scope prescribed in s.
78 626.241.

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

79 (2) However, an examination is not necessary for any of
80 the following:
81 (g) An applicant for a license as a life or health agent
82 who has received the designation of chartered life underwriter
83 (CLU) from the American College of Financial Services ~~Life~~
84 ~~Underwriters and has been engaged in the insurance business~~
85 ~~within the past 4 years~~, except that the applicant may be
86 examined on pertinent provisions of this code.
87 (h) An applicant for license as a general lines agent,
88 personal lines agent, or all-lines ~~customer representative, or~~
89 adjuster who has received the designation of chartered property
90 and casualty underwriter (CPCU) from the American Institute for
91 Chartered Property Casualty ~~and Liability~~ Underwriters ~~and has~~
92 ~~been engaged in the insurance business within the past 4 years~~,
93 except that the applicant may be examined on pertinent
94 provisions of this code.
95 (i) An applicant for license as a general lines agent or
96 an all-lines adjuster who has received a degree in insurance
97 from an accredited institution of higher learning approved by
98 the department, except that the applicant may be examined on
99 pertinent provisions of this code. Qualifying degrees must
100 indicate a minimum of 18 credit hours of insurance instruction,
101 including specific instruction in the areas of property,
102 casualty, health, and commercial insurance ~~customer~~
103 ~~representative who has earned the designation of Accredited~~
104 ~~Advisor in Insurance (AAI) from the Insurance Institute of~~

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

105 ~~America, the designation of Certified Insurance Counselor (CIC)~~
106 ~~from the Society of Certified Insurance Service Counselors, the~~
107 ~~designation of Accredited Customer Service Representative (ACSR)~~
108 ~~from the Independent Insurance Agents of America, the~~
109 ~~designation of Certified Professional Service Representative~~
110 ~~(CPSR) from the National Foundation for Certified Professional~~
111 ~~Service Representatives, the designation of Certified Insurance~~
112 ~~Service Representative (CISR) from the Society of Certified~~
113 ~~Insurance Service Representatives, or the designation of~~
114 ~~Certified Insurance Representative (CIR) from the National~~
115 ~~Association of Christian Catastrophe Insurance Adjusters. Also,~~
116 ~~an applicant for license as a customer representative who has~~
117 ~~earned an associate degree or bachelor's degree from an~~
118 ~~accredited college or university and has completed at least 9~~
119 ~~academic hours of property and casualty insurance curriculum, or~~
120 ~~the equivalent, or has earned the designation of Certified~~
121 ~~Customer Service Representative (CCSR) from the Florida~~
122 ~~Association of Insurance Agents, or the designation of~~
123 ~~Registered Customer Service Representative (RCSR) from a~~
124 ~~regionally accredited postsecondary institution in this state,~~
125 ~~or the designation of Professional Customer Service~~
126 ~~Representative (PCSR) from the Professional Career Institute,~~
127 ~~whose curriculum has been approved by the department and which~~
128 ~~includes comprehensive analysis of basic property and casualty~~
129 ~~lines of insurance and testing at least equal to that of~~
130 ~~standard department testing for the customer representative~~

131 ~~license. The department shall adopt rules establishing standards~~
132 ~~for the approval of curriculum~~.
133 (j) An applicant for license as a personal lines agent who
134 has received a degree from an accredited institution of higher
135 learning approved by the department, except that the applicant
136 may be examined on pertinent provisions of this code. Qualifying
137 degrees must indicate a minimum of 9 credit hours of insurance
138 instruction, including specific instruction in the areas of
139 property, casualty, and inland marine insurance ~~resident or~~
140 ~~nonresident all-lines adjuster who has the designation of~~
141 ~~Accredited Claims Adjuster (ACA) from a regionally accredited~~
142 ~~postsecondary institution in this state, Professional Claims~~
143 ~~Adjuster (PCA) from the Professional Career Institute,~~
144 ~~Professional Property Insurance Adjuster (PPIA) from the~~
145 ~~HurriClaim Training Academy, Certified Adjuster (CA) from ALL~~
146 ~~LINES Training, or Certified Claims Adjuster (CCA) from the~~
147 ~~Association of Property and Casualty Claims Professionals whose~~
148 ~~curriculum has been approved by the department and which~~
149 ~~includes comprehensive analysis of basic property and casualty~~
150 ~~lines of insurance and testing at least equal to that of~~
151 ~~standard department testing for the all-lines adjuster license.~~
152 ~~The department shall adopt rules establishing standards for the~~
153 ~~approval of curriculum~~.
154 (k) An applicant qualifying for a license transfer under
155 s. 626.292 ~~if the applicant:~~
156 ~~1. Has successfully completed the prelicensing examination~~

157 ~~requirements in the applicant's previous home state which are~~
158 ~~substantially equivalent to the examination requirements in this~~
159 ~~state, as determined by the department;~~
160 ~~2. Has received the designation of chartered property and~~
161 ~~casualty underwriter (CPCU) from the American Institute for~~
162 ~~Property and Liability Underwriters and been engaged in the~~
163 ~~insurance business within the past 4 years if applying to~~
164 ~~transfer a general lines agent license; or~~
165 ~~3. Has received the designation of chartered life~~
166 ~~underwriter (CLU) from the American College of Life Underwriters~~
167 ~~and been engaged in the insurance business within the past 4~~
168 ~~years if applying to transfer a life or health agent license~~.
169 (1) An applicant for a license as a nonresident agent if
170 the applicant holds a comparable license in another state with
171 similar examination requirements as this state~~:~~
172 ~~1. Has successfully completed prelicensing examination~~
173 ~~requirements in the applicant's home state which are~~
174 ~~substantially equivalent to the examination requirements in this~~
175 ~~state, as determined by the department, as a requirement for~~
176 ~~obtaining a resident license in his or her home state;~~
177 ~~2. Held a general lines agent license, life agent license,~~
178 ~~or health agent license before a written examination was~~
179 ~~required;~~
180 ~~3. Has received the designation of chartered property and~~
181 ~~casualty underwriter (CPCU) from the American Institute for~~
182 ~~Property and Liability Underwriters and has been engaged in the~~

183 ~~insurance business within the past 4 years, if an applicant for~~
184 ~~a nonresident license as a general lines agent; or~~
185 ~~4. Has received the designation of chartered life~~
186 ~~underwriter (CLU) from the American College of Life Underwriters~~
187 ~~and been in the insurance business within the past 4 years, if~~
188 ~~an applicant for a nonresident license as a life agent or health~~
189 ~~agent~~.
190 Section 4. Subsections (1), (2), (3), and (8) of section
191 626.241, Florida Statutes, are amended to read:
192 626.241 Scope of examination.—
193 (1) Each examination for a license as an agent~~, customer~~
194 ~~representative,~~ or adjuster shall be of such scope as is deemed
195 by the department to be reasonably necessary to test the
196 applicant's ability and competence and knowledge of the kinds of
197 insurance and transactions to be handled under the license
198 applied for, of the duties and responsibilities of such a
199 licensee, and of the pertinent provisions of the laws of this
200 state.
201 (2) Examinations given applicants for license as a general
202 lines agent ~~or customer representative~~ shall cover all property,
203 casualty, and surety insurances, except as provided in
204 subsection (5) relative to limited licenses.
205 (3) Examinations given applicants for a life agent's
206 license shall cover life insurance, annuities, and variable
207 contracts ~~annuities~~.
208 (8) An examination for licensure as a personal lines agent

209 ~~shall consist of 100 questions and~~ shall be limited in scope to
210 the kinds of business transacted under such license.
211 Section 5. Section 626.2817, Florida Statutes, is amended
212 to read:
213 626.2817 Regulation of course providers, instructors, and
214 school officials~~, and monitor groups~~ involved in prelicensure
215 education for insurance agents and other licensees.—
216 (1) Any course provider, instructor, or school official~~,~~
217 ~~or monitor group~~ must be approved by and registered with the
218 department before offering prelicensure education courses for
219 insurance agents and other licensees.
220 (2) The department shall adopt rules establishing
221 standards for the approval, registration, discipline, or removal
222 from registration of course providers, instructors, and school
223 officials~~, and monitor groups~~. The standards must be designed to
224 ensure that such persons have the knowledge, competence, and
225 integrity to fulfill the educational objectives of the
226 prelicensure requirements of this chapter and chapter 648 and to
227 assure that insurance agents and licensees are competent to
228 engage in the activities authorized under the license.
229 (3) A course provider shall not grant completion credit to
230 any student who has not completed at least 75 percent of the
231 required course hours of a department approved prelicensure
232 course.
233 (4) The department shall adopt rules to establish a
234 process for determining compliance with the prelicensure

235 requirements of this chapter and chapter 648. The department
236 shall adopt rules prescribing the forms necessary to administer
237 the prelicensure requirements.
238 Section 6. Subsection (1) of section 626.311, Florida
239 Statutes, is amended to read:
240 626.311 Scope of license.—
241 (1) Except as to personal lines agents and limited
242 licenses, a general lines agent or customer representative shall
243 qualify for all property, marine, casualty, and surety lines
244 except bail bonds which require a separate license under chapter
245 648. The license of a general lines agent ~~may~~ also covers ~~cover~~
246 health insurance ~~if health insurance is included in the agent's~~
247 ~~appointment by an insurer as to which the licensee is also~~
248 ~~appointed as agent for property or casualty or surety insurance~~.
249 The license of a customer representative shall provide, in
250 substance, that it covers all of such classes of insurance that
251 his or her appointing general lines agent or agency is currently
252 so authorized to transact under the general lines agent's
253 license and appointments. No such license shall be issued
254 limited to particular classes of insurance except for bail bonds
255 which require a separate license under chapter 648 or for
256 personal lines agents. Personal lines agents are limited to
257 transacting business related to property and casualty insurance
258 sold to individuals and families for noncommercial purposes.
259 Section 7. Subsections (1) through (5) of section 626.732,
260 Florida Statutes, are amended to read:

261 626.732 Requirement as to knowledge, experience, or
262 instruction.—
263 (1) Except as provided in subsection (4), an applicant for
264 a license as a general lines agent, except for a chartered
265 property and casualty underwriter (CPCU), may not be qualified
266 or licensed unless, within the 4 years immediately preceding the
267 date the application for license is filed with the department,
268 the applicant has:
269 (a) Taught or successfully completed 200 hours of
270 coursework in property, casualty, surety, health, and marine
271 insurance approved by the department ~~classroom courses in~~
272 ~~insurance~~, 3 hours of which must be on the subject matter of
273 ethics~~, at a school, college, or extension division thereof,~~
274 ~~approved by the department~~;
275 ~~(b) Completed a correspondence course in insurance, 3~~
276 ~~hours of which must be on the subject matter of ethics, which is~~
277 ~~regularly offered by accredited institutions of higher learning~~
278 ~~in this state or extensions thereof and approved by the~~
279 ~~department, and have at least 6 months of responsible insurance~~
280 ~~duties as a substantially full-time bona fide employee in all~~
281 ~~lines of property and casualty insurance set forth in the~~
282 ~~definition of general lines agent under s. 626.015;~~
283 (b)~~(c)~~ Completed at least 1 year in responsible insurance
284 duties as a substantially full-time bona fide employee in all
285 lines of property and casualty insurance as set forth in the
286 definition of a general lines agent under s. 626.015, but

287 without the education requirement described in paragraph (a) ~~or~~
288 ~~paragraph (b)~~; or
289 (c) ~~(d)~~ Completed at least 1 year of responsible insurance
290 duties as a licensed and appointed customer representative,
291 service representative, or personal lines agent ~~or limited~~
292 ~~customer representative in commercial or personal lines of~~
293 ~~property and casualty insurance~~ and 40 hours of coursework
294 ~~classroom courses~~ approved by the department covering the areas
295 of property, casualty, surety, health, and marine insurance~~; or~~
296 ~~(e) Completed at least 1 year of responsible insurance~~
297 ~~duties as a licensed and appointed service representative in~~
298 ~~commercial or personal lines of property and casualty insurance~~
299 ~~and 80 hours of classroom courses approved by the department~~
300 ~~covering the areas of property, casualty, surety, health, and~~
301 ~~marine insurance~~.
302 (2) Except as provided under subsection (4), an applicant
303 for a license as a personal lines agent, except for a chartered
304 property and casualty underwriter (CPCU), may not be qualified
305 or licensed unless, within the 4 years immediately preceding the
306 date the application for license is filed with the department,
307 the applicant has:
308 (a) Taught or successfully completed 60 hours of
309 coursework in property, casualty, and inland marine insurance
310 approved by the department ~~classroom courses in insurance~~, 3
311 hours of which must be on the subject matter of ethics~~, at a~~
312 ~~school, college, or extension division thereof, approved by the~~

313 ~~department. To qualify for licensure, the applicant must~~
314 ~~complete a total of 52 hours of classroom courses in insurance~~;
315 ~~(b) Completed a correspondence course in insurance, 3~~
316 ~~hours of which must be on the subject matter of ethics, which is~~
317 ~~regularly offered by accredited institutions of higher learning~~
318 ~~in this state or extensions thereof and approved by the~~
319 ~~department, and completed at least 3 months of responsible~~
320 ~~insurance duties as a substantially full-time employee in the~~
321 ~~area of property and casualty insurance sold to individuals and~~
322 ~~families for noncommercial purposes;~~
323 (b) ~~(c)~~ Completed at least 6 months of responsible
324 insurance duties as a substantially full-time employee in the
325 area of property and casualty insurance sold to individuals and
326 families for noncommercial purposes, but without the education
327 requirement described in paragraph (a) ~~or paragraph (b)~~; or
328 (c) ~~(d)~~ Completed at least 6 months of responsible
329 insurance duties as a licensed and appointed customer
330 representative, ~~or~~ limited customer representative, or service
331 representative in property and casualty insurance ~~sold to~~
332 ~~individuals and families for noncommercial purposes and 20 hours~~
333 ~~of classroom courses approved by the department which are~~
334 ~~related to property and casualty insurance sold to individuals~~
335 ~~and families for noncommercial purposes;~~
336 ~~(e) Completed at least 6 months of responsible insurance~~
337 ~~duties as a licensed and appointed service representative in~~
338 ~~property and casualty insurance sold to individuals and families~~

339 ~~for noncommercial purposes and 40 hours of classroom courses~~
340 ~~approved by the department related to property and casualty~~
341 ~~insurance sold to individuals and families for noncommercial~~
342 ~~purposes; or~~
343 ~~(f) Completed at least 3 years of responsible duties as a~~
344 ~~licensed and appointed customer representative in property and~~
345 ~~casualty insurance sold to individuals and families for~~
346 ~~noncommercial purposes~~.
347 (3) If an applicant's qualifications as required under
348 subsection (1) or subsection (2) are based in part upon periods
349 of employment in responsible insurance duties, the applicant
350 shall submit with the license application~~, on a form prescribed~~
351 ~~by the department,~~ an <u>attestation</u> ~~affidavit~~ of his or her
352 <u>employment</u> ~~employer~~ setting forth the period of such employment~~,~~
353 ~~that the employment was substantially full-time,~~ and giving a
354 brief abstract of the nature of the duties performed ~~by the~~
355 ~~applicant~~.
356 (4) An individual who was or became qualified to sit for
357 an agent's~~, customer representative's,~~ or adjuster's examination
358 at or during the time he or she was employed by the department
359 or office and who, while so employed, was employed in
360 responsible insurance duties as a full-time bona fide employee
361 may take an examination if application for such examination is
362 made within <u>4 years</u> ~~90 days~~ after the date of termination of
363 employment with the department or office.
364 (5) ~~Classroom and correspondence~~ Courses under subsections

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

365 (1) and (2) must include instruction on the subject matter of
366 unauthorized entities engaging in the business of insurance. ~~The~~
367 ~~scope of the topic of unauthorized entities must include the~~
368 ~~Florida Nonprofit Multiple-Employer Welfare Arrangement Act and~~
369 ~~the Employee Retirement Income Security Act, 29 U.S.C. ss. 1001~~
370 ~~et seq., as it relates to the provision of health insurance by~~
371 ~~employers and the regulation thereof.~~
372 Section 8. Subsections (3) and (7) of section 626.7351,
373 Florida Statutes, are amended to read:
374 626.7351 Qualifications for customer representative's
375 license.—The department shall not grant or issue a license as
376 customer representative to any individual found by it to be
377 untrustworthy or incompetent, or who does not meet each of the
378 following qualifications:
379 (3) Within 4 ~~the 2~~ years ~~next~~ preceding the date that the
380 application for license was filed with the department, the
381 applicant has earned the designation of Accredited Advisor in
382 Insurance (AAI), Associate in General Insurance (AINS), or
383 Accredited Customer Service Representative (ACSR) from the
384 Insurance Institute of America; the designation of Certified
385 Insurance Counselor (CIC) from the Society of Certified
386 Insurance Service Counselors; the designation of Certified
387 Professional Service Representative (CPSR) from the National
388 Foundation for CPSR; the designation of Certified Insurance
389 Service Representative (CISR) from the Society of Certified
390 Insurance Service Representatives; the designation of Certified

391 Insurance Representative (CIR) from All-Lines Training; the
392 designation of Professional Customer Service Representative
393 (PCSR) from the Professional Career Institute; the designation
394 of Registered Customer Service Representative (RCSR) from a
395 regionally accredited postsecondary institution in the state
396 whose curriculum is approved by the department and includes
397 comprehensive analysis of basic property and casualty lines of
398 insurance and testing which demonstrates mastery of the subject;
399 or a degree from an accredited institution of higher learning
400 approved by the department when the degree includes a minimum of
401 9 credit hours of insurance instruction, including specific
402 instruction in the areas of property, casualty, and inland
403 marine insurance. The department shall adopt rules establishing
404 standards for the approval of curriculum ~~completed a course in~~
405 ~~insurance, 3 hours of which shall be on the subject matter of~~
406 ~~ethics, approved by the department or has had at least 6 months'~~
407 ~~experience in responsible insurance duties as a substantially~~
408 ~~full-time employee. Courses must include instruction on the~~
409 ~~subject matter of unauthorized entities engaging in the business~~
410 ~~of insurance. The scope of the topic of unauthorized entities~~
411 ~~shall include the Florida Nonprofit Multiple-Employer Welfare~~
412 ~~Arrangement Act and the Employee Retirement Income Security Act,~~
413 ~~29 U.S.C. ss. 1001 et seq., as such acts relate to the provision~~
414 ~~of health insurance by employers and the regulation of such~~
415 ~~insurance~~.
416 ~~(7) The applicant has passed any required examination for~~

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

417 ~~license required under s. 626.221.~~
418 Section 9. Section 626.748, Florida Statutes, is amended
419 to read:
420 626.748 Agent's records.—Every agent transacting any
421 insurance policy must maintain in his or her office, or have
422 readily accessible by electronic or photographic means, for a
423 period of at least 5 years after policy expiration, such records
424 of policies transacted by him or her as to enable the
425 policyholders and department to obtain all necessary
426 information, including daily reports, applications, change
427 endorsements, or documents signed or initialed by the insured
428 concerning such policies.
429 Section 10. Section 626.7851, Florida Statutes, is amended
430 to read:
431 626.7851 Requirement as to knowledge, experience, or
432 instruction.—An ~~No~~ applicant for a license as a life agent,
433 except for a chartered life underwriter (CLU), shall not be
434 qualified or licensed unless within the 4 years immediately
435 preceding the date the application for a license is filed with
436 the department he or she has:
437 (1) Successfully completed 40 hours of coursework
438 ~~classroom courses~~ in life insurance, annuities, and variable
439 contracts approved by the department, 3 hours of which shall be
440 on the subject matter of ethics~~, satisfactory to the department~~
441 ~~at a school or college, or extension division thereof, or other~~
442 ~~authorized course of study, approved by the department~~. Courses

443 must include instruction on the subject matter of unauthorized
444 entities engaging in the business of insurance~~, to include the~~
445 ~~Florida Nonprofit Multiple-Employer Welfare Arrangement Act and~~
446 ~~the Employee Retirement Income Security Act, 29 U.S.C. ss. 1001~~
447 ~~et seq., as it relates to the provision of life insurance by~~
448 ~~employers to their employees and the regulation thereof~~;
449 (2) Earned or maintained an active designation as a
450 Chartered Financial Consultant (ChFC) from the American College
451 of Financial Services; Fellow, Life Management Institute (FLMI)
452 from the Life Management Institute; or Certified Financial
453 Planner (CFP) from the Certified Financial Planner Board of
454 Standards ~~Successfully completed a correspondence course in~~
455 ~~insurance, 3 hours of which shall be on the subject matter of~~
456 ~~ethics, satisfactory to the department and regularly offered by~~
457 ~~accredited institutions of higher learning in this state or by~~
458 ~~independent programs of study, approved by the department.~~
459 ~~Courses must include instruction on the subject matter of~~
460 ~~unauthorized entities engaging in the business of insurance, to~~
461 ~~include the Florida Nonprofit Multiple-Employer Welfare~~
462 ~~Arrangement Act and the Employee Retirement Income Security Act,~~
463 ~~29 U.S.C. ss. 1001 et seq., as it relates to the provision of~~
464 ~~life insurance by employers to their employees and the~~
465 ~~regulation thereof~~;
466 (3) Held an active license in life~~, or life and health,~~
467 insurance in another state. This provision may not be used
468 ~~utilized~~ unless the other state grants reciprocal treatment to

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

469 licensees formerly licensed in the state ~~Florida~~; or
470 (4) Been employed by the department or office for at least
471 1 year, full time in life ~~or life and health~~ insurance
472 regulatory matters and who was not terminated for cause, and
473 application for examination is made within 4 years ~~90 days~~ after
474 the date of termination of his or her employment with the
475 department or office.
476 Section 11. Section 626.8311, Florida Statutes, is amended
477 to read:
478 626.8311 Requirement as to knowledge, experience, or
479 instruction.—An ~~No~~ applicant for a license as a health agent,
480 except for a chartered life underwriter (CLU), shall not be
481 qualified or licensed unless within the 4 years immediately
482 preceding the date the application for license is filed with the
483 department he or she has:
484 (1) Successfully completed 40 hours of coursework
485 ~~classroom courses~~ in health insurance, approved by the
486 department, 3 hours of which shall be on the subject matter of
487 ethics~~, satisfactory to the department at a school or college,~~
488 ~~or extension division thereof, or other authorized course of~~
489 ~~study, approved by the department~~. Courses must include
490 instruction on the subject matter of unauthorized entities
491 engaging in the business of insurance, to include the Florida
492 Nonprofit Multiple-Employer Welfare Arrangement Act and the
493 Employee Retirement Income Security Act, 29 U.S.C. ss. 1001 et
494 seq., as it relates to the provision of health insurance by

495 employers to their employees and the regulation thereof;
496 (2) Earned or maintained an active designation as a
497 Registered Health Underwriter (RHU), Chartered Healthcare
498 Consultant (ChHC), or Registered Employee Benefits Consultant
499 (REBC) from the American College of Financial Services;
500 Certified Employee Benefit Specialist (CEBS) from the Wharton
501 School of the University of Pennsylvania; Health Insurance
502 Associate (HIA) from America's Health Insurance Plans; or
503 Certified Financial Planner (CFP) from the Certified Financial
504 Planner Board of Standards ~~Successfully completed a~~
505 ~~correspondence course in insurance, 3 hours of which shall be on~~
506 ~~the subject matter of ethics, satisfactory to the department and~~
507 ~~regularly offered by accredited institutions of higher learning~~
508 ~~in this state or by independent programs of study, approved by~~
509 ~~the department. Courses must include instruction on the subject~~
510 ~~matter of unauthorized entities engaging in the business of~~
511 ~~insurance, to include the Florida Nonprofit Multiple Employer~~
512 ~~Welfare Arrangement Act and the Employee Retirement Income~~
513 ~~Security Act, 29 U.S.C. ss. 1001 et seq., as it relates to the~~
514 ~~provision of health insurance by employers to their employees~~
515 ~~and the regulation thereof~~;
516 (3) Held an active license in health~~, or life and health,~~
517 insurance in another state. This provision may not be utilized
518 unless the other state grants reciprocal treatment to licensees
519 formerly licensed in Florida; or
520 (4) Been employed by the department or office for at least

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

521 1 year, full time in health insurance regulatory matters and who
522 was not terminated for cause, and application for examination is
523 made within 4 years ~~90 days~~ after the date of termination of his
524 or her employment with the department or office.
525 Section 12. Section 626.8661, Florida Statutes, is created
526 to read:
527 626.8661 Requirement as to knowledge, experience, or
528 instruction.—An applicant for a license as an all-lines
529 adjuster, except for a chartered property and casualty
530 underwriter (CPCU), shall not be qualified or licensed unless
531 within the 4 years immediately preceding the date that the
532 application for license is filed with the department he or she
533 has:
534 (1) Successfully completed 40 hours of coursework in
535 adjusting all lines of insurance, except life, approved by the
536 department;
537 (2) Earned or maintained an active designation as an
538 Accredited Claims Adjuster (ACA) from a regionally accredited
539 postsecondary institution in the state, Associate in Claims
540 (AIC) from the Insurance Institute of America, Professional
541 Claims Adjuster (PCA) from the Professional Career Institute,
542 Professional Property Insurance Adjuster (PPIA) from the
543 HurriClaim Training Academy, Certified Adjuster (CA) from All-
544 Lines Training, or Certified Claims Adjuster (CCA) from AE21
545 Incorporated;
546 (3) Completed at least 1 year in responsible insurance

547 duties as a substantially full-time insurance adjuster with
548 experience in determining the amount of a claim, loss, or damage
549 payable under an insurance contract and has effected settlement
550 of such claim, loss, or damage, but has not met the education
551 requirement described in subsection (1) or subsection (2); or
552 (4) Been employed full time by the department or office
553 for at least 1 year, with experience in insurance claim
554 regulatory matters, and was not terminated for cause.
555 Section 13. Paragraph (o) of subsection (1) of section
556 626.9541, Florida Statutes, is amended to read:
557 626.9541 Unfair methods of competition and unfair or
558 deceptive acts or practices defined.—
559 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
560 ACTS.—The following are defined as unfair methods of competition
561 and unfair or deceptive acts or practices:
562 (o) Illegal dealings in premiums; excess or reduced
563 charges for insurance.—
564 1. Knowingly collecting any sum as a premium or charge for
565 insurance, which is not then provided, or is not in due course
566 to be provided, subject to acceptance of the risk by the
567 insurer, by an insurance policy issued by an insurer as
568 permitted by this code.
569 2. Knowingly collecting as a premium or charge for
570 insurance any sum in excess of or less than the premium or
571 charge applicable to such insurance, in accordance with the
572 applicable classifications and rates as filed with and approved

573 by the office, and as specified in the policy; or, in cases when
574 classifications, premiums, or rates are not required by this
575 code to be so filed and approved, premiums and charges collected
576 from a Florida resident in excess of or less than those
577 specified in the policy and as fixed by the insurer.
578 Notwithstanding any other provision of law, this provision shall
579 not be deemed to prohibit the charging and collection, by
580 surplus lines agents licensed under part VIII of this chapter,
581 of the amount of applicable state and federal taxes, or fees as
582 authorized by s. 626.916(4), in addition to the premium required
583 by the insurer or the charging and collection, by licensed
584 agents, of the exact amount of any discount or other such fee
585 charged by a credit card facility in connection with the use of
586 a credit card, as authorized by subparagraph (q)3., in addition
587 to the premium required by the insurer. This subparagraph shall
588 not be construed to prohibit collection of a premium for a
589 universal life or a variable or indeterminate value insurance
590 policy made in accordance with the terms of the contract.
591 3.a. Imposing or requesting an additional premium for a
592 policy of motor vehicle liability, personal injury protection,
593 medical payment, or collision insurance or any combination
594 thereof or refusing to renew the policy solely because the
595 insured was involved in a motor vehicle accident unless the
596 insurer's file contains information from which the insurer in
597 good faith determines that the insured was substantially at
598 fault in the accident.

599 b. An insurer which imposes and collects such a surcharge
600 or which refuses to renew such policy shall, in conjunction with
601 the notice of premium due or notice of nonrenewal, notify the
602 named insured that he or she is entitled to reimbursement of
603 such amount or renewal of the policy under the conditions listed
604 below and will subsequently reimburse him or her or renew the
605 policy, if the named insured demonstrates that the operator
606 involved in the accident was:
607 (I) Lawfully parked;
608 (II) Reimbursed by, or on behalf of, a person responsible
609 for the accident or has a judgment against such person;
610 (III) Struck in the rear by another vehicle headed in the
611 same direction and was not convicted of a moving traffic
612 violation in connection with the accident;
613 (IV) Hit by a "hit-and-run" driver, if the accident was
614 reported to the proper authorities within 24 hours after
615 discovering the accident;
616 (V) Not convicted of a moving traffic violation in
617 connection with the accident, but the operator of the other
618 automobile involved in such accident was convicted of a moving
619 traffic violation;
620 (VI) Finally adjudicated not to be liable by a court of
621 competent jurisdiction;
622 (VII) In receipt of a traffic citation which was dismissed
623 or nolle prossed; or
624 (VIII) Not at fault as evidenced by a written statement

625 from the insured establishing facts demonstrating lack of fault
626 which are not rebutted by information in the insurer's file from
627 which the insurer in good faith determines that the insured was
628 substantially at fault.
629 c. In addition to the other provisions of this
630 subparagraph, an insurer may not fail to renew a policy if the
631 insured has had only one accident in which he or she was at
632 fault within the current 3-year period. However, an insurer may
633 nonrenew a policy for reasons other than accidents in accordance
634 with s. 627.728. This subparagraph does not prohibit nonrenewal
635 of a policy under which the insured has had three or more
636 accidents, regardless of fault, during the most recent 3-year
637 period.
638 4. Imposing or requesting an additional premium for, or
639 refusing to renew, a policy for motor vehicle insurance solely
640 because the insured committed a noncriminal traffic infraction
641 as described in s. 318.14 unless the infraction is:
642 a. A second infraction committed within an 18-month
643 period, or a third or subsequent infraction committed within a
644 36-month period.
645 b. A violation of s. 316.183, when such violation is a
646 result of exceeding the lawful speed limit by more than 15 miles
647 per hour.
648 5. Upon the request of the insured, the insurer and
649 licensed agent shall supply to the insured the complete proof of
650 fault or other criteria which justifies the additional charge or

651 cancellation.
652 6. No insurer shall impose or request an additional
653 premium for motor vehicle insurance, cancel or refuse to issue a
654 policy, or refuse to renew a policy because the insured or the
655 applicant is a handicapped or physically disabled person, so
656 long as such handicap or physical disability does not
657 substantially impair such person's mechanically assisted driving
658 ability.
659 7. No insurer may cancel or otherwise terminate any
660 insurance contract or coverage, or require execution of a
661 consent to rate endorsement, during the stated policy term for
662 the purpose of offering to issue, or issuing, a similar or
663 identical contract or coverage to the same insured with the same
664 exposure at a higher premium rate or continuing an existing
665 contract or coverage with the same exposure at an increased
666 premium.
667 8. No insurer may issue a nonrenewal notice on any
668 insurance contract or coverage, or require execution of a
669 consent to rate endorsement, for the purpose of offering to
670 issue, or issuing, a similar or identical contract or coverage
671 to the same insured at a higher premium rate or continuing an
672 existing contract or coverage at an increased premium without
673 meeting any applicable notice requirements.
674 9. No insurer shall, with respect to premiums charged for
675 motor vehicle insurance, unfairly discriminate solely on the
676 basis of age, sex, marital status, or scholastic achievement.

677 10. Imposing or requesting an additional premium for motor
678 vehicle comprehensive or uninsured motorist coverage solely
679 because the insured was involved in a motor vehicle accident or
680 was convicted of a moving traffic violation.
681 11. No insurer shall cancel or issue a nonrenewal notice
682 on any insurance policy or contract without complying with any
683 applicable cancellation or nonrenewal provision required under
684 the Florida Insurance Code.
685 12. No insurer shall impose or request an additional
686 premium, cancel a policy, or issue a nonrenewal notice on any
687 insurance policy or contract because of any traffic infraction
688 when adjudication has been withheld and no points have been
689 assessed pursuant to s. 318.14(9) and (10). However, this
690 subparagraph does not apply to traffic infractions involving
691 accidents in which the insurer has incurred a loss due to the
692 fault of the insured.
693 Section 14. Section 627.4553, Florida Statutes, is amended
694 to read:
695 627.4553 Recommendations to surrender.—If an insurance
696 agent recommends the surrender of an annuity or life insurance
697 policy containing a cash value and does not recommend that the
698 proceeds from the surrender be used to fund or purchase another
699 annuity or life insurance policy, before execution of the
700 surrender, the insurance agent~~, or insurance company if no agent~~
701 ~~is involved,~~ shall provide written ~~, on a form that satisfies~~
702 ~~the requirements of the rule adopted by the department,~~

703 information relating to the annuity or policy to be surrendered.
704 Such information shall include, but is not limited to, the
705 amount of any surrender charge, the loss of any minimum interest
706 rate guarantees, the possibility ~~amount~~ of ~~any~~ tax consequences
707 ~~resulting from the transaction~~, the amount of any forfeited
708 death benefit, and the value of any other investment performance
709 guarantees being forfeited as a result of the transaction. The
710 agent shall maintain a copy of the information and the date that
711 the information was provided to the owner. This section also
712 applies to a person performing insurance agent activities
713 pursuant to an exemption from licensure under this part.
714 Section 15. Subsection (2) of section 631.341, Florida
715 Statutes, is amended to read:
716 631.341 Notice of insolvency to policyholders by insurer,
717 general agent, or agent.—
718 (2) Unless, within 15 days subsequent to the date of such
719 notice, all agents referred to in subsection (1) have either
720 replaced or reinsured in a solvent authorized insurer the
721 insurance coverages placed by or through such agent in the
722 delinquent insurer, such agents shall then, by registered or
723 certified mail, or by e-mail with delivery receipt required,
724 send to the last known address of any policyholder a written
725 notice of the insolvency of the delinquent insurer.
726 Section 16. Paragraph (d) of subsection (1) of section
727 648.355, Florida Statutes, is amended to read:
728 648.355 Temporary limited license as limited surety agent

729 or professional bail bond agent; pending examination.—
730 (1) The department may, in its discretion, issue a
731 temporary license as a limited surety agent or professional bail
732 bond agent, subject to the following conditions:
733 (d) Within 4 years prior to the date of application for a
734 temporary license, the applicant has successfully completed a
735 basic certification course in the criminal justice system,
736 consisting of <u>at least</u> ~~not less than~~ 120 hours of ~~classroom~~
737 instruction with a passing grade of 80 percent or higher and has
738 successfully completed a <u>20 hour</u> ~~correspondence~~ course for bail
739 bond agents approved by the department.
740 Section 17. Paragraph (a) of subsection (1) of section
741 648.386, Florida Statutes, is amended to read:
742 648.386 Qualifications for prelicensing and continuing
743 education schools and instructors.—
744 (1) SCHOOLS AND CURRICULUM FOR PRELICENSING SCHOOLS.—In
745 order to be considered for approval and certification as an
746 approved limited surety agent and professional bail bond agent
747 prelicensing school, such entity must:
748 (a)1. Offer a ~~minimum of two~~ 120-hour ~~classroom-~~
749 ~~instruction~~ basic certification <u>course</u> ~~courses~~ in the criminal
750 justice system <u>approved by the department</u> ~~per calendar year~~
751 ~~unless a reduced number of course offerings per calendar year is~~
752 ~~warranted in accordance with rules promulgated by the~~
753 ~~department~~; or
754 2. Offer a <u>bail bond agents</u> ~~department-approved~~

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

755 ~~correspondence~~ course <u>approved by the</u> ~~pursuant to~~ department
756 ~~rules~~.
757 Section 18. This act shall take effect July 1, 2015.

Insurance & Banking Subcommittee

HB 1133 by Rep. Fant
Division of Insurance Agent and Agency Services

AMENDMENT SUMMARY
March 18, 2015

Amendment 1 by Rep. Fant (Line 133): The amendment creates examination exemptions for personal lines agent, life agent, and health agent applicants with qualifying academic degrees and restores current law regarding the examination exemption for all-lines adjusters.

Amendment 2 by Rep. Fant (Line 449): The amendment revises the knowledge, experience, or instruction requirements applicable to life agent and health agent applicants and deletes section 12 of the bill, which would have created knowledge, experience, or instruction requirements applicable to all-lines adjusters.

Amendment 3 by Rep. Santiago (Line 695): The amendment creates a definition of the term "surrender" for purposes of the surrender of an annuity or life insurance policy and establishes a 14-day notice period prior to effectuating surrenders.

Amendment 4 by Rep. Fant (Line 726): The amendment removes sections 16 and 17 of the bill that revised training requirements for bail bond agents.

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	____	

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Fant offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 133-153 and insert:
7 (j) An applicant for license as an ~~resident or nonresident~~
8 all-lines adjuster who has the designation of Accredited Claims
9 Adjuster (ACA) from a regionally accredited postsecondary
10 institution in this state, <u>Associate in Claims (AIC) from the</u>
11 <u>Insurance Institute of America,</u> Professional Claims Adjuster
12 (PCA) from the Professional Career Institute, Professional
13 Property Insurance Adjuster (PPIA) from the HurriClaim Training
14 Academy, Certified Adjuster (CA) from ALL LINES Training, or
15 Certified Claims Adjuster (CCA) from <u>AE21 incorporated</u> ~~the~~
16 ~~Association of Property and Casualty Claims Professionals~~ whose
17 curriculum has been approved by the department and which

18 includes comprehensive analysis of basic property and casualty
19 lines of insurance and testing at least equal to that of
20 standard department testing for the all-lines adjuster license.
21 The department shall adopt rules establishing standards for the
22 approval of curriculum.

23 (k) An applicant for license as a personal lines agent who
24 has received a degree from an accredited institution of higher
25 learning approved by the department, except that the applicant
26 may be examined on pertinent provisions of this code. Qualifying
27 degrees must indicate a minimum of 9 credit hours of insurance
28 instruction, including specific instruction in the areas of
29 property, casualty, and inland marine insurance.

30 (l) An applicant for license as a life agent who has
31 received a degree from an accredited institution of higher
32 learning approved by the department, except that the applicant
33 may be examined on pertinent provisions of this code.
34 Qualifying degrees must indicate a minimum of 9 credit hours of
35 insurance instruction, including specific instruction in the
36 areas of life insurance, annuities and variable insurance
37 products.

38 (m) An applicant for license as a health agent who has
39 received a degree from an accredited institution of higher
40 learning approved by the department, except that the applicant
41 may be examined on pertinent provisions of this code.
42 Qualifying degrees must indicate a minimum of 9 credit hours of

43 insurance instruction, including specific instruction in the
44 area of health insurance products.
45
46
47 ---
48 **T I T L E A M E N D M E N T**
49 Remove line 11 and insert:
50 agent, or all-lines adjuster; creating examination requirements
51 and qualifications for an exemption from examination for
52 personal lines agents; creating examination requirements and
53 qualifications for an exemption from examination for life
54 agents; creating examination requirements and qualifications for
55 an exemption from examination for health agents; amending s.
56 626.241,

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 Fant offered the following:

Amendment (with title amendment)

Remove lines 449-554 and insert:

(2) Successfully completed a minimum of 60 hours of coursework in multiple areas of insurance, which included life insurance, annuities, and variable contracts, approved by the department, 3 hours of which shall be on the subject matter of ethics. Courses must include instruction on the subject matter of unauthorized entities engaging in the business of insurance;

(3) Earned or maintained an active designation as Chartered Financial Consultant (ChFC) from the American College of Financial Services; or Fellow, Life Management Institute (FLMI) from the Life Management Institute; ~~Successfully completed a correspondence course in insurance, 3 hours of which shall be on~~

18 ~~the subject matter of ethics, satisfactory to the department and~~
19 ~~regularly offered by accredited institutions of higher learning~~
20 ~~in this state or by independent programs of study, approved by~~
21 ~~the department. Courses must include instruction on the subject~~
22 ~~matter of unauthorized entities engaging in the business of~~
23 ~~insurance, to include the Florida Nonprofit Multiple-Employer~~
24 ~~Welfare Arrangement Act and the Employee Retirement Income~~
25 ~~Security Act, 29 U.S.C. ss. 1001 et seq., as it relates to the~~
26 ~~provision of life insurance by employers to their employees and~~
27 ~~the regulation thereof~~;
28 (4) ~~(3)~~ Held an active license in life~~, or life and~~
29 ~~health,~~ insurance in another state. This provision may not be
30 used ~~utilized~~ unless the other state grants reciprocal treatment
31 to licensees formerly licensed in the state ~~Florida~~; or
32 (5) ~~(4)~~ Been employed by the department or office for at
33 least 1 year, full time in life ~~or life and health~~ insurance
34 regulatory matters and who was not terminated for cause, and
35 application for examination is made within 4 years ~~90 days~~ after
36 the date of termination of his or her employment with the
37 department or office.
38 Section 11. Section 626.8311, Florida Statutes, is
39 amended to read:
40 626.8311 Requirement as to knowledge, experience, or
41 instruction.—An ~~No~~ applicant for a license as a health agent,
42 except for a chartered life underwriter (CLU), shall not be
43 qualified or licensed unless within the 4 years immediately

44 preceding the date the application for license is filed with the
45 department he or she has:
46 (1) Successfully completed 40 hours of coursework
47 ~~classroom courses~~ in health insurance, approved by the
48 department, 3 hours of which shall be on the subject matter of
49 ethics~~, satisfactory to the department at a school or college,~~
50 ~~or extension division thereof, or other authorized course of~~
51 ~~study, approved by the department~~. Courses must include
52 instruction on the subject matter of unauthorized entities
53 engaging in the business of insurance, to include the Florida
54 Nonprofit Multiple-Employer Welfare Arrangement Act and the
55 Employee Retirement Income Security Act, 29 U.S.C. ss. 1001 et
56 seq., as it relates to the provision of health insurance by
57 employers to their employees and the regulation thereof;
58 (2) Successfully completed a minimum of 60 hours of
59 coursework in multiple areas of insurance, which included health
60 insurance, approved by the department, 3 hours of which shall be
61 on the subject matter of ethics. Courses must include
62 instruction on the subject matter of unauthorized entities
63 engaging in the business of insurance;
64 (3) Earned or maintained an active designation as a
65 Registered Health Underwriter (RHU), Chartered Healthcare
66 Consultant (ChHC), or Registered Employee Benefits Consultant
67 (REBC) from the American College of Financial Services;
68 Certified Employee Benefit Specialist (CEBS) from the Wharton
69 School of the University of Pennsylvania; or Health Insurance

70 Associate (HIA) from America's Health Insurance Plans;
71 ~~Successfully completed a correspondence course in insurance, 3~~
72 ~~hours of which shall be on the subject matter of ethics,~~
73 ~~satisfactory to the department and regularly offered by~~
74 ~~accredited institutions of higher learning in this state or by~~
75 ~~independent programs of study, approved by the department.~~
76 ~~Courses must include instruction on the subject matter of~~
77 ~~unauthorized entities engaging in the business of insurance, to~~
78 ~~include the Florida Nonprofit Multiple-Employer Welfare~~
79 ~~Arrangement Act and the Employee Retirement Income Security Act,~~
80 ~~29 U.S.C. ss. 1001 et seq., as it relates to the provision of~~
81 ~~health insurance by employers to their employees and the~~
82 ~~regulation thereof~~;
83 (4) ~~(3)~~ Held an active license in health~~, or life and~~
84 ~~health,~~ insurance in another state. This provision may not be
85 utilized unless the other state grants reciprocal treatment to
86 licensees formerly licensed in Florida; or
87 (5) ~~(4)~~ Been employed by the department or office for at
88 least 1 year, full time in health insurance regulatory matters
89 and who was not terminated for cause, and application for
90 examination is made within 4 years ~~90 days~~ after the date of
91 termination of his or her employment with the department or
92 office.
93
94 ---
95 T I T L E A M E N D M E N T

96 Remove lines 28-30 and insert:

97 agents and health agents, respectively;

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 1133 (2015)

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 Santiago offered the following:

Amendment (with title amendment)

Remove lines 695-713 and insert:

627.4553 Recommendations to surrender.—

(1) If an insurance agent recommends the surrender of an annuity or life insurance policy containing a cash value and does not recommend that the proceeds from the surrender be used to fund or purchase another annuity or life insurance policy, before execution of the surrender, the insurance agent~~, or insurance company if no agent is involved,~~ shall provide written ~~, on a form that satisfies the requirements of the rule adopted by the department,~~ information relating to the annuity or policy to be surrendered. The written information must be delivered at or after the time of the recommendation but no later than 14

18 days prior to the surrender of the annuity or life insurance
19 policy. If the owner requests to terminate the surrender prior
20 to the surrender being effectuated, the surrender must be
21 cancelled. Such information shall include, but is not limited
22 to, the amount of any estimated surrender charge, the loss of
23 any minimum interest rate guarantees, the possibility ~~amount~~ of
24 ~~any~~ tax consequences ~~resulting from the transaction~~, the
25 estimated amount of any forfeited death benefit, and a
26 description of ~~the value of~~ any other investment performance
27 guarantees being forfeited as a result of the transaction. The
28 agent shall maintain a copy of the information and the date that
29 the information was provided to the owner. This section also
30 applies to a person performing insurance agent activities
31 pursuant to an exemption from licensure under this part.

32 (2) For purposes of this section, the term "surrender"
33 means the voluntary total surrender, by the owner's request, of
34 the annuity or life insurance policy before its maturity date,
35 in exchange for the policy's current total cash surrender value
36 and resulting in termination of the policy or contract. The term
37 "surrender" excludes any involuntary termination that is
38 otherwise required by the terms of the policy contract and
39 excludes all transactions other than a total surrender, such as
40 maturity, policy loan, lapse for non-payment of premium, a
41 partial surrender or partial withdrawal of policy or contract
42 values, annuitization, or exercise of reduced-paid-up or
43 extended-term non-forfeiture options.

44

45 ---

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

47 Remove line 37 and insert:

48 insurance policy under certain circumstances; prohibiting

49 surrender under certain circumstances; creating a definition;

50 amending

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 ___

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Fant offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 726-756
7
8
9 ---
10 **T I T L E A M E N D M E N T**
11 Remove lines 40-46 and insert:
12 methods; providing an effective date.
13

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7047 PCB HIS 15-02 Direct Primary Care
SPONSOR(S): Health Innovation Subcommittee, Costello
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Innovation Subcommittee		Poche	Poche
1) Insurance & Banking Subcommittee		Peterson KP	Cooper
2) Health & Human Services Committee			

SUMMARY ANALYSIS

Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship. Through a contractual agreement, a patient pays a monthly fee, usually between $50 and $100 per individual, to the primary care provider for defined primary care services. After paying the fee, a patient can utilize all services under the agreement at no extra charge. Some DPC practices also include routine preventative services, women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

HB 7047 provides that a direct primary care agreement (agreement) and the act of entering into such an agreement are not insurance and not subject to regulation under the Florida Insurance Code (Code). The bill also exempts a primary care provider, or his or her agent, from any certification or licensure requirements in the Code for marketing, selling, or offering to sell an agreement. An agreement must:

- Be in writing;
- Be signed by the primary care provider, or his or her agent, and the patient, or the patient's legal representative;
- Allow either party to terminate the agreement by written notice followed by a waiting period;
- Describe the scope of services that are covered by the monthly fee;
- Specify the monthly fee and any fees for services not covered under the agreement;
- Specify the duration of the agreement and any automatic renewal provisions;
- Provide for a refund to the patient of monthly fees paid in advance if the primary care provider stops offering primary care services for any reason;
- State that the agreement is not health insurance; and
- Not indemnify for services provided by a third person.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Office of Insurance Regulation

The Florida Office of Insurance Regulation (OIR) regulates the business of insurance in the state, in accordance with the Florida Insurance Code (Code). The specific chapters under the Code are:

Chapter 624, F.S. – Insurance Code: Administration and General Provisions
Chapter 625, F.S. – Accounting, Investments, and Deposits by Insurers
Chapter 626, F.S. – Insurance Field Representatives and Operations
Chapter 627, F.S. – Insurance Rates and Contracts
Chapter 628, F.S. – Stock and Mutual Insurers; Holding Companies
Chapter 629, F.S. – Reciprocal Insurers
Chapter 630, F.S. – Alien Insurers: Trusteed Assets; Domestication
Chapter 631, F.S. – Insurer Insolvency; Guaranty of Payment
Chapter 632, F.S. – Fraternal Benefit Societies
Chapter 634, F.S. – Warranty Associations
Chapter 635, F.S. – Mortgage Guaranty Insurance
Chapter 636, F.S. – Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations
Chapter 641, F.S. – Health Care Service Programs
Chapter 648, F.S. – Bail Bond Agents
Chapter 651, F.S. – Continuing Care Contracts

The Life and Health Unit (Unit) of OIR provides financial oversight of health insurers, health maintenance organizations, and other regulated entities providing health care coverage. The Unit also reviews and approves some health care coverage products offered in the state. The following chart shows the type and number of each entity in the state:[1]

Authority Category	Authorities
Health Insurers	448
Third Party Administrators	310
Continuing Care Retirement Communities	61
Discount Medical Plan Organizations	40
Health Maintenance Organizations	38
Fraternal Benefit Societies	36
Prepaid Limited Health Service Organizations/Prepaid Health Clinics	28

Direct Primary Care

Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship. Through a contractual agreement, a patient pays a

[1] Rich Robleto, FLORIDA OFFICE OF INSURANCE REGULATION, *Health Insurance Regulatory Responsibilities of the Office of Insurance Regulation*, PowerPoint presentation before the House Health Innovation Subcommittee, January 21, 2015, slide 7 (using data compiled on March 21, 2014 from NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS Insurance, *Department Resources Report for CY 2013*)(on file with the House Insurance & Banking Subcommittee).

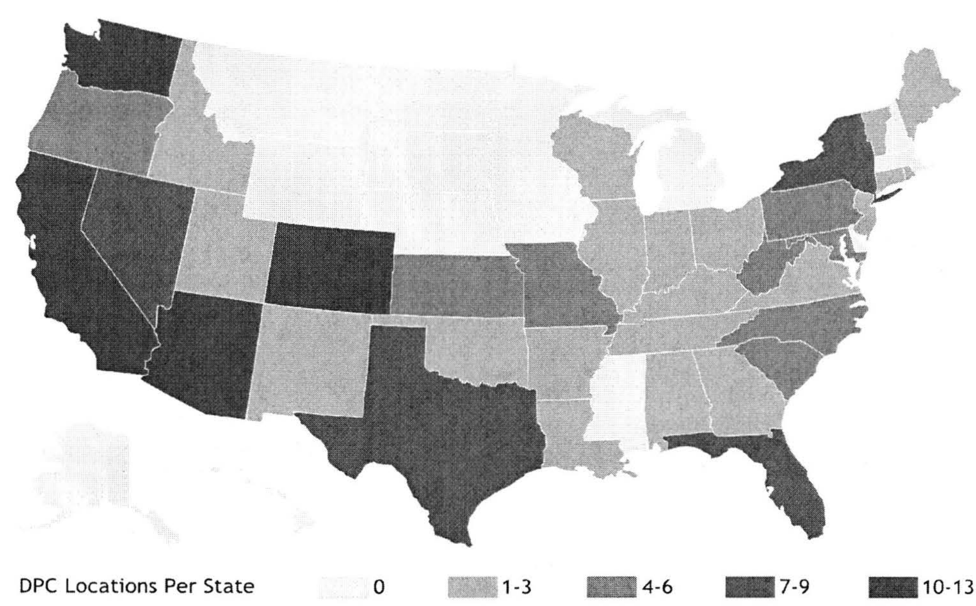
monthly fee, usually between $50 and $100 per individual,[2] to the primary care provider for defined primary care services. Theses primary care services may include:

- Office visits;
- Annual physical examination;
- Routine laboratory tests;
- Vaccinations;
- Wound care;[3]
- Splinting or casting of fractured or broken bones;
- Other routine testing, e.g. echocardiogram and colon cancer screening; or
- Other medically necessary primary care procedures.

After paying the fee, a patient can utilize all services under the agreement at no extra charge. Some DPC practices also include routine preventative services, like lab tests, mammograms, Pap screenings, and vaccinations. A primary care provider DPC model can be designed to address the large majority of health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

In the DPC practice model, the primary care provider eliminates practice overhead costs associated with filing claims, coding, refiling claims, write-offs, appealing denials, and employing billing staff. The cost and time savings can be reinvested in the practice, allowing more time with patients to address their primary care needs.

The following chart illustrates the concentration of DPC practices in the United States:[4]



There are an estimated 4,400 direct primary care physicians nationwide, up from 756 in 2010.[5]

---

[2] Approximately two thirds of DPC practices charge less than $135 per month. Jen Wieczner, *Is Obamacare Driving Doctors to Refuse Insurance?*, WALL ST. J. MARKETWATCH, Nov. 12, 2013, *available at* http://www.marketwatch.com/story/is-direct-primary-care-for-you-2013-11-12 (last visited March 12, 2015).

[3] *e.g.*, stitches and sterile dressings.

[4] Jay Keese, DIRECT PRIMARY CARE COALITION, *Direct Primary Care*, PowerPoint presentation before the House Health Innovation Subcommittee, slide 4, February 17, 2015 (on file with the House Insurance & Banking Subcommittee).

[5] Daniel McCorry, *Direct Primary Care: An Innovative Alternative to Conventional Health Insurance*,THE HERITAGE FOUNDATION BACKGROUNDER, No. 2939 (Aug. 6, 2014), *available at* http://report.heritage.org/bg2939 (last visited March 12, 2015).

DPC and Health Care Reform

The Patient Protection and Affordable Care Act (PPACA)[6] addresses the DPC practice model as part of health care reform. A qualified health plan under PPACA is permitted to offer coverage through a DPC medical home plan if it provides essential health benefits and meets all other criteria in the law.[7] Patients who are enrolled in a DPC medical home plan are exempt from the individual mandate if they have coverage for other services, such as a wraparound catastrophic health policy to cover treatment for serious illnesses, like cancer, or severe injuries that require lengthy hospital stays and rehabilitation.[8] In Colorado and Washington, qualified health plans are offering DPC medical home coverage on each state-based health insurance exchange.[9]

Effect of Proposed Changes

The bill provides that a direct primary care agreement is not insurance and entering into such an agreement is not the business of insurance and exempts both the agreement and the activity from the Code. Through the exemption, the bill eliminates any authority of OIR to regulate a direct primary care agreement or entering into such an agreement. The bill also exempts a primary care provider, or his or her agent, from certification or licensing requirements under the Code to market, sell, or offer to sell a direct primary care agreement.

The bill requires a direct primary care agreement to:

- Be in writing;
- Be signed by the primary care provider, or his or her agent, and the patient, or the patient's legal representative;
- Allow either party to terminate the agreement by written notice followed by a waiting period;
- Describe the scope of services that are covered by the monthly fee;
- Specify the monthly fee and any fees for services not covered under the agreement;
- Specify the duration of the agreement and any automatic renewal provisions;
- Provide for a refund to the patient of monthly fees paid in advance if the primary care provider stops offering primary care services for any reason; and
- State that the agreement is not health insurance.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 624.27, F.S., relating to application of code as to direct primary care agreements.
Section 2: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[6] Pub. L. No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).
[7] 42 U.S.C. §1802 (a)(3); 45 C.F.R. §156.245
[8] 42 U.S.C. §18021(a)(3)
[9] Robleto, *Supra* note 5, slide 2.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill removes any regulatory uncertainty as to the status of a direct primary care agreement as insurance. Primary care providers may choose to invest in establishing direct primary care practices throughout the state to provide primary care services, which would increase access to such services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The 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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to direct primary care; creating s.
3 624.27, F.S.; providing definitions; specifying that a
4 direct primary care agreement does not constitute
5 insurance and is not subject to the Florida Insurance
6 Code; specifying that entering into a direct primary
7 care agreement does not constitute the business of
8 insurance and that such action is not subject to the
9 Florida Insurance Code; providing that a certificate
10 of authority is not required to market, sell, or offer
11 to sell a direct primary care agreement; specifying
12 criteria for a direct primary care agreement;
13 providing an effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Section 624.27, Florida Statutes, is created to
18 read:
19 624.27 Application of code as to direct primary care
20 agreements.—
21 (1) As used in this section, the term:
22 (a) "Direct primary care agreement" means a contract
23 between a primary care provider and a patient or the patient's
24 legal representative which meets the criteria in subsection (4)
25 and does not indemnify for services provided by a third party.
26 (b) "Primary care provider" means a health care provider

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

27 licensed under chapter 458, chapter 459, or chapter 464 who
28 provides medical services to patients which are commonly
29 provided without referral from another health care provider.
30 (c) "Primary care service" means the screening,
31 assessment, diagnosis, and treatment of a patient for the
32 purpose of promoting health or detecting and managing disease or
33 injury within the competency and training of the primary care
34 provider.
35 (2) A direct primary care agreement does not constitute
36 insurance and is not subject to this code. The act of entering
37 into a direct primary care agreement does not constitute the
38 business of insurance and such action is not subject to this
39 code.
40 (3) A primary care provider or an agent of a primary care
41 provider is not required to obtain a certificate of authority or
42 license under this code to market, sell, or offer to sell a
43 direct primary care agreement.
44 (4) For purposes of this section, a direct primary care
45 agreement must:
46 (a) Be in writing.
47 (b) Be signed by the primary care provider or an agent of
48 the primary care provider and the patient or the patient's legal
49 representative.
50 (c) Allow a party to terminate the agreement by written
51 notice to the other party after a period specified in the
52 agreement.

53 (d) Describe the scope of primary care services that are
54 covered by the monthly fee.
55 (e) Specify the monthly fee and any fees for primary care
56 services not covered by the monthly fee.
57 (f) Specify the duration of the agreement and any
58 automatic renewal provisions.
59 (g) Offer a refund to the patient of monthly fees paid in
60 advance if the primary care provider ceases to offer primary
61 care services for any reason.
62 (h) State that the agreement is not health insurance.
63 Section 2. This act shall take effect July 1, 2015.

Insurance & Banking Subcommittee

HB 7047 by Health Innovation and Costello
Citizens Property Insurance Corporation

AMENDMENT SUMMARY
March 18, 2015

Amendment 1 by Rep. Costello (Line 23): The amendment allows primary care group practices and employers to be parties to a DPC agreement.

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 ___

---

1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Costello offered the following:
4
5 **Amendment**
6 Remove lines 23-24 and insert:
7 between a primary care provider or a primary care group practice
8 and a patient or the patient's legal representative or an
9 employer which meets the criteria in subsection (4)

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 669 Insurance Claims
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

Generally, an assignment of benefits allows a third party to collect insurance proceeds owed to the policyholder directly from the insurance company. Consequently, the proceeds are not paid to the policyholder. Assignments of benefits are commonly used in health insurance and personal injury protection insurance. In health insurance, a policyholder typically assigns his or her benefits for a covered medical service to the health care provider. Thus, the treating physician gets paid directly from the insurer.

Assignment of benefits are becoming more common in property insurance claims, particularly in water damage claims where a homeowner assigns his or her benefits on their property insurance policy to a contractor or water remediation company who repairs the damaged property (hereinafter collectively referred to as a "vendor"). With losses caused by water damage, such as leaky pipes, the homeowner is often in an emergency position where he or she must mitigate the damage before further damage is caused. This often involves calling a water restoration company to the home to immediately mitigate and prevent further flooding.

Current law provides that an insurance policy may be assignable, or not assignable, as provided by its terms. The law allows for an insurance policy to prohibit a pre-loss assignment of benefit. However, it is unclear whether an insurance policy may include language prohibiting the assignment of post-loss benefits.

- This bill clarifies that a property insurance policy may prohibit the assignment of post-loss benefits except in certain limited circumstances.

Current law requires a person seeking to enforce a property insurance policy to have an insurable interest in the property at the time of the loss. An insurable interest means an actual interest in the safety or preservation of the insured property. There is current debate regarding whether an assignee of post-loss property insurance benefits has an insurable interest in covered property such that they could enforce the contract of insurance.

- This bill clarifies that insurable interest does not survive assignment, except when assigned to a subsequent purchaser of covered property.

Current law requires public adjusters to be qualified and licensed by the Department of Financial Services. Contractors and subcontractors are prohibited from adjusting a claim on behalf of an insured unless licensed and compliant as a public adjuster. However, contractors may discuss or explain a bid for construction or repair of the insured property if doing so is part of the usual and customary fees applicable to the work being performed as provided by contract. Current law also prohibits public adjusters from participating, directly or indirectly, in the repair or restoration of property that is the subject of a claim adjusted by the licensee, or engaging in any other activities that could reasonably be construed as a conflict of interest.

- This bill clarifies that any assignment or agreement that purports to assign to a contractor or subcontractor the authority to adjust, negotiate, or settle any portion of a claim is void.

Current law prescribes various timeframes for an insurer's duties regarding property insurance claims.

- This bill shortens the timeframes associated with property insurance claims, requiring insurers to fulfill certain duties related to property insurance claims quicker.

The bill does not have a fiscal impact on the state or on local governments. It may have a positive but indeterminate fiscal impact on the private sector.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background on Issue

Generally, an assignment of benefits (AOB) allows a third party to collect insurance proceeds owed to the policyholder directly from the insurance company. Consequently, the proceeds are not paid to the policyholder. AOBs are commonly used in health insurance and personal injury protection insurance. In health insurance, a policyholder typically assigns his or her benefits for a covered medical service to the health care provider. Thus, the treating physician gets paid directly from the insurer.

AOBs are becoming more common in property insurance claims, particularly in water damage claims where a homeowner assigns his or her benefits on their property insurance policy to a contractor or water remediation company who repairs the damaged property (hereinafter collectively referred to as a "vendor").

With losses caused by water damage, such as leaky pipes, the homeowner is often in an emergency position where he or she must mitigate the damage before further damage is caused. This often involves calling a water restoration company to the home to immediately mitigate and prevent further flooding. Some insurers assert AOBs to a vendor in a water damage claim can be problematic because if the vendor submits an invoice to the insurer that is more than what the insurer estimates it should cost to remediate and dry-out the policyholder's residence, the insurer must investigate the claim, determine why the invoice is higher than estimated by the insurer, and identify whether all the work indicated in the invoice was performed. Insurance policies typically provide authority for the insurer to take certain actions to investigate claims, such as requiring policyholders to file proofs of loss, to produce records, and submit to examinations under oath. However, vendors obtaining an AOB for the claim many times allege they do not have to comply the insurer's claims investigation authorized under the insurance policy because they agreed only to an assignment of the insurance benefits and did not agree to assume any of the duties under the insurance policy.[1]

In testimony before the Insurance & Banking Subcommittee, Citizens Property Insurance Company ("Citizens") reported that 70% of the property insurance claims in 2014 were caused by water damage, 56% of which caused by non-weather water damage.[2] Such water damage claims appear to be highest in the counties of Miami-Dade, Broward, and Palm Beach (collectively referred to as the "Tri-County").[3] Citizens reported that of the volume of water damage claims from 2014, 72% were from the Tri-County.[4] Further, the results of a Citizens 2013 litigation study revealed that 75% of all 2013 litigation involved water claims.[5]

Assignability of Insurance Policies

Background on Assignability of Insurance Policies

Currently, Florida law provides that "a policy may be assignable, or not assignable, as provided by its terms."[6] An AOB can occur in two circumstances: pre-loss AOBs and post-loss AOBs. A pre-loss AOB occurs before a policyholder experiences a loss, and a post-loss AOB occurs after a policyholder

---

[1] Florida House of Representatives Regulatory Affairs Committee, Staff Analysis of 2013 CS/CS/HB 909, p. 2 (Apr. 18, 2013).
[2] Citizens Property Insurance Corporation, Citizens Presentation on Assignment of Benefits (Feb. 9, 2015), on file with Insurance & Banking Subcommittee.
[3] Id.
[4] Id.
[5] Id.
[6] s. 627.422, F.S.

experiences a loss. Florida law allows an insurance company to include language in the policy prohibiting pre-loss AOBs.[7] However, it is less clear whether Florida law allows an insurance company to include language in the policy prohibiting post-loss AOBs; this question is currently on appeal to the Florida First District Court of Appeal.[8]

Florida case law provides that "a provision in a policy of insurance which prohibits assignment thereof except with the consent of the insurer does not apply to prevent assignment of the claim or interest in the insurance money then due, after loss."[9] In other words, an insurer can include a provision in a property insurance policy that prohibits a policyholder from assigning his or her policy to a third party. However, such a prohibition does not prohibit the policyholder from assigning his or her rights under the policy once a claim arises.[10] The purpose of a no-assignment provision in a policy is to protect an insurer against unbargained-for risks.[11] One reason a post-loss assignment is valid despite a provision prohibiting assignment without consent of the insurer is that once a loss occurs, the financial exposure of the insurance company does not change. If a post-loss AOB is made, the assignee cannot assert new rights of his or her own that did not belong to the assignor.

The current debate regarding the assignability of a property insurance policy is whether an insurer can include language in the policy prohibiting the assignment of post-loss benefits.[12]

Effect of the PCS ("the Bill") on Assignability of Insurance Policies

This bill amends s. 627.422, F.S., allowing a property insurance policy to prohibit the post-loss assignment of rights, benefits, causes of action, or other contractual rights under the policy, except in limited circumstances. The bill provides that the insured in a property insurance policy nonetheless has the right to make the following assignments:

- The insured may assign the benefit of payment not to exceed $3,000 to a vendor providing services or materials to mitigate or repair damage directly arising from a covered loss. However, such assignment is limited solely to the ability to be named as a copayee for the benefit of payment for the reasonable value of services rendered and materials provided to mitigate or repair such damage. The insured may not assign the right to enforce payment of the post-loss benefits contained in the policy. In other words, even if the insured does make an assignment to a vendor, the vendor cannot itself enforce payment under the policy.
- The insured may make an assignment for the limited purposes of compensating a public adjuster for services as authorized by s. 626.854(11), F.S. Such an assignment is solely for the purposes of compensating the public adjuster.
- The insured may make an assignment for payment of an attorney representing the insured. Such assignment only contemplates that the benefits are paid to the attorney representing the insured, and that the insured will disperse the funds to repair the property at the direction of the insured.

The bill also adds language clarifying that any post-loss assignment in contravention of the statute will be rendered void.

---

[7] Id.
[8] Security First Ins. Co. v. Fla. Office of Ins. Reg., No. 1D14-1864 (Fla. 1st DCA) (notice of appeal filed Apr. 25, 2014).
[9] Gisela Invs. ,N.V. v. Liberty Mut. Ins. Co., 452 So. 2d 1056 (Fla. 3d DCA 1984); see also West Florida Grocery Co. v. Teutonia Fire Ins. Co., 77 So. 209, 224 (Fla. 1917) ("[I]t is a well-settled rule that the provision in a policy relative to the consent of the insurer to the transfer of an interest does not apply to an assignment after loss."); Better Construction, Inc. v. National Union Fire Ins. Co., 651 So. 2d 141, 142 ("[A] provision against assignment of an insurance policy does not bar an insured's assignment of an after-loss claim."); Highlands Ins. Co. v. Kravecas, 719 So. 2d 320, 321 (Fla. 3d DCA 1998).
[10] See Florida House of Representatives Regulatory Affairs Committee, Staff Analysis of 2013 CS/CS/HB 909, p. 2 (Apr. 18, 2013).
[11] Lexington Ins. Co. v. Simkins Industries, Inc., 704 So. 2d 1384, 1386 (Fla. 1998).
[12] See Security First Ins. Co. v. Fla. Office of Ins. Reg., No. 1D14-1864 (Fla. 1st DCA) (notice of appeal filed Apr. 25, 2014).

Insurable Interest

Background on Insurable Interest

To enforce a property insurance contract, a person must have an insurable interest in the insured property. Specifically, Florida law provides: "No contract of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss."[13] Florida law defines "insurable interest" in the property insurance context as "any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage from impairment."[14] "The measure of insurable interest in property is the extent to which the insured might be damnified by loss, injury, or impairment thereof."[15]

The test for the existence of an insurable interest in the insured property is whether, at the time of the loss, one "benefits from [the property's] existence and would suffer loss from its damage or destruction."[16]

Current law provides that a contract of property insurance cannot be enforced in court without an insurable interest.[17] There is currently debate over whether the vendor, by virtue of an AOB, has an insurable interest in the insured property such that it can enforce the contract of insurance following a loss.[18]

Effect of the Bill on Insurable Interest

This bill amends s. 627.405, F.S., clarifying that an insurable interest does not survive an assignment, except to a subsequent purchaser of the property who acquires an insurable interest following a loss. Thus, if an insurer allowed a policyholder to assign the post-loss benefit of payment to a person or entity providing services or materials to mitigate or repair a loss, such assignee would not itself be able to bring suit to enforce payment.

If the insured property is sold, the bill provides that a subsequent purchaser can acquire an insurable interest following a loss. Thus, if the insured property experiences a loss and the policyholder sells the property together with the contract of property insurance, the purchaser would have an insurable interest that would not preclude the enforcement of the contract of insurance.

Public Adjusters

Background on Public Adjusters

Public adjusters are required to be qualified and licensed by the Department of Financial Services (DFS). A public adjuster is a person "who, for money, commission, or any other thing of value, prepares, completes, or files an insurance claim form for an insured or third-party claimant or who, for money, commission, or any other thing of value, acts on behalf of, or aids an insured or third-party claimant in negotiating for or effecting the settlement of a claim or claims for loss or damage covered by an insurance contract or who advertises for employment as an adjuster of such claims."[19]

---

[13] s. 627.405(1), F.S.
[14] s. 627.405(2), F.S.
[15] s. 627.405(3), F.S.
[16] Peninsular Fire Ins. Co. v. Fowler, 166 So. 2d 206 (Fla. 2d DCA 1964).
[17] See s. 627.405, F.S.
[18] This has been brought up in briefing in three cases currently up on appeal to the Florida Fourth District Court of Appeal. See 'Drafting Issues or Other Comments' for further discussion.
[19] s. 626.854(1), F.S.

There are currently other limitations and regulations regarding public adjusting. For example, a licensed contractor or subcontractor may not adjust a claim on behalf of an insured unless licensed and compliant as a public adjuster under chapter 626, F.S.[20] However, the contractor may discuss or explain a bid for construction or repair of covered property with the residential property owner who has suffered a loss or damage covered by a property insurance policy, or the insurer of such property, if the contractor is doing so for the usual and customary fees applicable to the work to be performed as stated in the contract between the contractor and the insured.[21]

Current law also contains a public adjuster conflict of interest section that prohibits public adjusters from participating, directly or indirectly, in the reconstruction, repair, or remediation of the insured property that is the subject of the claim or engaging in any other activity that could reasonably be construed as a conflict of interest.[22]

Some trial courts in Florida have dismissed cases brought by a vendor through a purported AOB, reasoning that the vendor was in engaging in unlawful or unlicensed public adjusting. For example, in Emergency Services 24, Inc. v. American Traditions Ins. Co., the court dismissed a claim brought pursuant to a purported AOB, finding that the assignment was unauthorized under Florida law because it "holds Plaintiff out as a 'public adjuster' as defined in Florida Statute 626.854."[23] Further, in NextGen Restoration, Inc. v. Homeowners Choice Prop. & Cas. Ins. Co., the court conceded that "the right to receive post-loss insurance proceeds is assignable," but suggested that there is a lack of case law permitting the "assignment of a prospective insurance recovery whose amount has not yet been determined."[24] The court went on to state that "[e]stablishing that amount, fixing it as a sum certain, is the essence of 'adjusting' an insurance claim."[25] As such, the court dismissed the plaintiff's claim, holding that the claim, as pled, "fits the statutory definition of public adjusting . . . as defined in Section 626.854, Florida Statutes – which proscribes such conduct by contractors."[26] However, other trial courts in Florida have come out differently on this issue. For example, in Start to Finish Restoration, LLC v. Homeowners Choice Prop. & Cas. Ins. Co, the court denied the insurer's motion to dismiss, finding that the vendor did not hold itself out to be a public adjuster in contravention of statute because the allegations "simply indicate[d] Plaintiff permissibly received the assignment of rights to receive payments due and [was] acting solely for its own benefit."[27]

Effect of the Bill on Public Adjusters

This bill clarifies that any assignment or agreement purporting to transfer the authority to adjust, negotiate, or settle any portion of a claim to a contractor or subcontractor, or that is otherwise in derogation of the public adjuster contractor prohibition section is void. The bill appears to have the effect of prohibiting a vendor from disputing the amount of payment with the insurer under an AOB. Thus, if a property insurance policy permitted a post-loss AOB, the assignment would be limited to payment of a fixed amount to the vendor.

[20] s. 626.854(16), F.S.
[21] Id.
[22] "A public adjuster may not participate, directly or indirectly, in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the licensee; may not engage in any other activities that may be reasonably construed as a conflict of interest, including soliciting or accepting any remuneration from, of any kind or nature, directly or indirectly; and may not have a financial interest in any salvage, repair, or any other business entity that obtains business in connection with any claim that the public adjuster has a contract or an agreement to adjust." s. 626.8795, F.S.
[23] Emergency Services 24, Inc. v. American Traditions Ins. Co., No 12-CC-26928 (Fla. Hillsborough Cty. Ct. April 30, 2013).
[24] NextGen Restoration, Inc. v. Homeowners Choice Prop. & Cas. Ins. Co., No 12-012813-CI-19 (Fla. Pinellas Cty. Ct. July 17, 2013).
[25] Id.
[26] Id.
[27] Start to Finish Restoration, LLC v. Homeowners Choice Prop. & Cas. Ins. Co., No. 2012-CA-6605 (Fla. Manatee Cty. Ct. May 23, 2013).

Insurer's Duties and Timeframes with respect to Property Insurance Claims

Background on Insurer's Duties and Timeframes with respect to Property Insurance Claims

Current law prescribes various timeframes that insurers are required to comply with regarding property insurance claims. Current law provides that when an insurer receives initial communication with respect to a claim, the insurer must review and acknowledge receipt of the communication within 14 calendar days, unless payment is made within that period of time or unless the failure to acknowledge is caused by factors beyond the control of the insurer which reasonably prevent such acknowledgment.[28] If the acknowledgment is not in writing, a notification indicating acknowledgment must be made in the insurer's claim file and dated.[29] The acknowledgement must be responsive to the communication.[30] If the communication is a notification of a claim, the acknowledgment must provide necessary claim forms and instructions, including an appropriate telephone number, unless the acknowledgment reasonably advises the claimant that the claim appears not to be covered by the insurer.[31]

Unless otherwise provided by the policy or law, the insurer must begin such investigation as is reasonably necessary within 10 working days after receiving proof of loss statements, unless the failure to begin the investigation is caused by factors beyond the control of the insurer which reasonably prevent the commencement of such investigation.[32]

Current law codifies a Homeowner Claims Bill of Rights, describing some of the rights held by insurance policyholders.[33] The insurer is required to provide the policyholder with a copy of the Homeowner Claims Bill of Rights within 14 days of a claim; however the bill of rights does not create a new civil cause of action.[34] Among other things, the Homeowner Claims Bill of Rights states that upon written request, within 30 days after submitting a complete proof-of-loss statement to the insurer, the policyholder has the right to receive confirmation that his or her claim is covered in full, partially covered, or denied, or receive a written statement that his or her claim is being investigated.[35]

Further, Florida currently provides that a residential property insurer must pay or deny the property insurance claim or a portion of the claim within 90 days after receiving notice of the claim from the policyholder, unless the failure to pay is caused by factors beyond the control of the insurer which reasonably prevent such payment.[36]

Currently, there are protections in place for situations in which an insurer would be unable to meet such timeframes due to situations outside of their control, such as when there is a hurricane. As demonstrated above, most of the provisions excuse an insurer from fulfilling its obligation within the prescribed timeframe when the failure to do so is "caused by factors beyond the control of the insurer which reasonably prevent" strict compliance. Further, current law bestows certain powers to the Commissioner of Insurance (the "Commissioner") and the Governor in the case of a declared emergency:

- When the Governor declares a state of emergency, s. 252.63, F.S., provides the Commissioner with the authority to issue general orders applicable to all Florida insurance companies, entities, and persons[37]

---

[28] s. 627.70131(1)(a), F.S.
[29] Id.
[30] s. 627.70131(2), F.S.
[31] Id.
[32] s. 627.70131(3), F.S.
[33] s. 627.7142, F.S.
[34] Id.
[35] Id.
[36] s. 627.70131(5)(a), F.S.
[37] Such orders remain in effect for 120 day unless terminated sooner by the Commissioner, and can be extended for an additional 120 days. By concurrent resolution, the Legislature may terminate any order issued by the Commissioner under this section. s. 252.63(2), F.S.

- When the Governor declares a state of emergency, s. 252.36(5)(a), F.S., provides the Governor with the authority to suspend the provisions of any regulatory statute prescribing procedures for conduct of state business or the orders or rules of any state agency, if strict compliance with the provisions of any such statute, order, or rule would in any way prevent, hinder, or delay necessary action in coping with the emergency.

Effect of the Bill on Insurer's Duties and Timeframes with respect to Property Insurance Claims

This bill shortens some of the timeframes that insurers must comply with regarding property insurance claims. This bill may have the effect of requiring some insurers to alter some of their claims practices in order to meet the new statutory timeframes. Below is a table illustrating the various changes the bill provides to the statutory timeframes:

	Current Timeframe	**Timeframe Changed by Bill**
Upon receiving communication with respect to a claim, insurer must review and acknowledge receipt of communication within:	14 calendar days	7 calendar days
Upon receiving communication with respect to a claim, insurer must provide policyholder with Homeowner Claims Bill of Rights within:	14 days	7 days
Upon receiving proof of loss statements, insurer must begin such investigation as is reasonably necessary within:	10 days	Unchanged (10 days)
After insurer receives proof of loss, upon written request, insurer must provide policyholder with confirmation that claim is covered in full, partially covered, or denied, or provide written statement that the claim is being investigated, within:	30 days	15 days
Upon initial notice of claim, insurer must pay or deny such claim or part of such claim within:	90 days	45 days

The bill also requires a residential property insurer to respond within 7 days of receiving a communication in writing from a third party identified in s. 627.422(2)(a) – (c) with respect to the claim requesting the insurer acknowledge the existence of a policy of insurance on the property.

The bill does not change the statutory safeguards in place for exigent circumstances in which an insurer would be unable to meet the timeframe, such as a hurricane. The bill does not change the language in the statutes excusing the insurer from strict compliance with the timeframe when the failure to do so "is caused by factors beyond the control of the insurer which reasonably prevent" the insurer from performing such duties. Further, the powers bestowed upon the Commissioner and the Governor during a state of emergency would remain in place.

B. SECTION DIRECTORY:

Section 1. Amends s. 626.854, F.S., relating to public adjusters.

Section 2. Amends s. 627.405, F.S., relating to insurable interest; property.

Section 3. Amends s. 627.422, F.S., relating to assignment of policies.

Section 4. Amends s. 627.70131, F.S., relating to insurer's duty to acknowledge communications regarding claims; investigations.

Section 5. Amends s. 627.7142, F.S., relating to Homeowner Claims Bill of Rights.

Section 6. Provides an effective date of July 1, 2015.

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:

Indeterminate.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The 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:

There are currently three cases on appeal to the Florida Fourth District Court of Appeal. As of the date of this analysis, the three cases are all set for oral argument on March 24, 2015.

These cases and corresponding issues on appeal are as follows:

- ASAP Restoration and Constr., Inc. v. Tower Hill Signature Ins. Co., Case No. 4D13-4174
  - Issue: Whether the trial court erred as a matter of law in dismissing the vendor's complaint on the basis that the AOB was invalid under the anti-assignment and loss payment clauses of the policy?

- One Call Prop. Services, Inc. v. Security First Ins. Co., Case No. 4D14-0424
  - Issue: Whether the trial court erred as a matter of law in dismissing the vendor's complaint on the basis that the AOB was invalid under the anti-assignment and loss payment clauses of the policy?
- Emergency Services 24, Inc. v. United Prop. & Cas. Ins. Co., Case No. 4D14-0576
  - Issue: Whether the trial court erred in entering summary judgment in favor of the insurer on the basis that the vendor's AOB was invalid?

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to insurance claims; amending s.
3 626.854, F.S.; providing that an assignment or
4 agreement that transfers authority to adjust,
5 negotiate or settle a claim is void; amending s.
6 627.405, F.S.; prohibiting assignment of an insurable
7 interest except to subsequent purchasers after a loss;
8 amending s. 627.422, F.S.; authorizing an insurance
9 policy to prohibit assignment of post-loss benefits;
10 providing exceptions; amending s. 627.70131, F.S.;
11 decreasing timeframes for acknowledging and paying
12 claims; amending s. 627.7142, F.S.; making conforming
13 changes to the Homeowner's Bill of Rights; providing
14 an effective date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Subsection (16) of section 626.854, Florida
19 Statutes, is amended to read:
20 626.854 "Public adjuster" defined; prohibitions.—The
21 Legislature finds that it is necessary for the protection of the
22 public to regulate public insurance adjusters and to prevent the
23 unauthorized practice of law.
24 (16)(a) A licensed contractor under part I of chapter 489,
25 or a subcontractor, may not adjust a claim on behalf of an
26 insured unless licensed and compliant as a public adjuster under

27 this chapter. However, the contractor may discuss or explain a
28 bid for construction or repair of covered property with the
29 residential property owner who has suffered loss or damage
30 covered by a property insurance policy, or the insurer of such
31 property, if the contractor is doing so for the usual and
32 customary fees applicable to the work to be performed as stated
33 in the contract between the contractor and the insured.
34 (b) Any assignment or agreement that purports to transfer
35 the authority to adjust, negotiate, or settle any portion of a
36 claim to such contractor or subcontractor, or that is otherwise
37 in derogation of this section, is void.
38 Section 2. Section 627.405, Florida Statutes, is amended
39 to read:
40 627.405 Insurable interest; property.—
41 (1) No contract of insurance of property or of any
42 interest in property or arising from property shall be
43 enforceable as to the insurance except for the benefit of
44 persons having an insurable interest in the things insured as at
45 the time of the loss.
46 (2) "Insurable interest" as used in this section means any
47 actual, lawful, and substantial economic interest in the safety
48 or preservation of the subject of the insurance free from loss,
49 destruction, or pecuniary damage or impairment.
50 (3) The measure of an insurable interest in property is
51 the extent to which the insured might be damnified by loss,
52 injury, or impairment thereof.

53 (4) Insurable interest does not survive an assignment,
54 except to a subsequent purchaser of the property who acquires
55 insurable interest following a loss.
56 Section 3. Section 627.422, Florida Statutes, is amended
57 to read:
58 627.422 Assignment of policies; restrictions on post-loss
59 assignment of benefits.—
60 (1) A policy may be assignable, or not assignable, as
61 provided by its terms. Subject to its terms relating to
62 assignability, any life or health insurance policy under the
63 terms of which the beneficiary may be changed upon the sole
64 request of the policyowner may be assigned either by pledge or
65 transfer of title, by an assignment executed by the policyowner
66 alone and delivered to the insurer, whether or not the pledgee
67 or assignee is the insurer. Any such assignment shall entitle
68 the insurer to deal with the assignee as the owner or pledgee of
69 the policy in accordance with the terms of the assignment, until
70 the insurer has received at its home office written notice of
71 termination of the assignment or pledge or written notice by or
72 on behalf of some other person claiming some interest in the
73 policy in conflict with the assignment.
74 (2) A property insurance policy may prohibit the post-loss
75 assignment of rights, benefits, causes of action, or other
76 contractual rights under the policy, except:
77 (a) An insured may assign the benefit of payment not to
78 exceed $3,000 to a person or entity providing services or

79 materials to mitigate or repair damage directly arising from a
80 covered loss. The assignment is limited solely to the ability
81 to be named as a copayee for the benefit of payment for the
82 reasonable value of services rendered and materials provided to
83 mitigate or repair such damage. The insured may not assign the
84 right to enforce payment of the post-loss benefits contained in
85 the policy.
86 (b) For the limited purpose of compensating a public
87 adjuster for services authorized by s. 626.854(11). The
88 assignment is only for compensation due to the public adjuster
89 by the insured and not for the remainder of the benefits due to
90 the insured under the policy. Nothing in this paragraph changes
91 the obligations, if any, of the insurer to issue the insured a
92 check for payment in the name of the insured or mortgage holder.
93 (c) For payment of an attorney representing the insured,
94 wherein the assignment contemplates only that the benefits are
95 paid to the attorney representing the insured, and that the
96 attorney will disperse the funds to repair the property at the
97 direction of the insured.
98 (3) Any post-loss assignment of rights, benefits, causes
99 of action, or other contractual rights in contravention of this
100 section renders the assignment void.
101 Section 4. Subsections (1), (2), (3), and (4) and
102 paragraph (a) of subsection (5) of section 627.70131, Florida
103 Statutes, are amended to read:
104 627.70131 Insurer's duty to acknowledge communications

105 regarding claims; investigation.—
106 (1)(a) Upon an insurer's receiving a communication with
107 respect to a claim, the insurer shall, within ~~14~~ 7 calendar
108 days, review and acknowledge receipt of such communication
109 unless payment is made within that period of time or unless the
110 failure to acknowledge is caused by factors beyond the control
111 of the insurer which reasonably prevent such acknowledgment. If
112 the acknowledgment is not in writing, a notification indicating
113 acknowledgment shall be made in the insurer's claim file and
114 dated. A communication made to or by an agent of an insurer with
115 respect to a claim shall constitute communication to or by the
116 insurer. If a residential property insurer receives a
117 communication in writing from a third party identified in s.
118 627.422(2)(a)-(c) with respect to the claim requesting that the
119 insurer acknowledge the existence of a policy of insurance on
120 the property, the insurer shall respond within 7 days of the
121 request answering the communication. If the insurer's
122 acknowledgment is not in writing, a notification indicating
123 acknowledgment shall be made in the insurer's claim file and
124 dated.
125 (b) As used in this subsection, the term "agent" means any
126 person to whom an insurer has granted authority or
127 responsibility to receive or make such communications with
128 respect to claims on behalf of the insurer.
129 (c) This subsection shall not apply to claimants
130 represented by counsel beyond those communications necessary to

131 provide forms and instructions.
132 (2) Such acknowledgment shall be responsive to the
133 communication. If the communication constitutes a notification
134 of a claim, unless the acknowledgment reasonably advises the
135 claimant that the claim appears not to be covered by the
136 insurer, the acknowledgment shall provide necessary claim forms,
137 and instructions, including an appropriate telephone number.
138 (3) Unless otherwise provided by the policy of insurance
139 or by law, within 10 working days after an insurer receives
140 proof of loss statements, the insurer shall begin such
141 investigation as is reasonably necessary unless the failure to
142 begin such investigation is caused by factors beyond the control
143 of the insurer which reasonably prevent the commencement of such
144 investigation.
145 (4) For purposes of this section, the term "insurer" means
146 any residential property insurer.
147 (5)(a) Within ~~90~~ 45 days after an insurer receives notice
148 of an initial, reopened, or supplemental property insurance
149 claim from a policyholder, the insurer shall pay or deny such
150 claim or a portion of the claim unless the failure to pay is
151 caused by factors beyond the control of the insurer which
152 reasonably prevent such payment. Any payment of an initial or
153 supplemental claim or portion of such claim made ~~90~~ 45 days
154 after the insurer receives notice of the claim, or made more
155 than 15 days after there are no longer factors beyond the
156 control of the insurer which reasonably prevented such payment,

157 whichever is later, bears interest at the rate set forth in s.
158 55.03. Interest begins to accrue from the date the insurer
159 receives notice of the claim. The provisions of this subsection
160 may not be waived, voided, or nullified by the terms of the
161 insurance policy. If there is a right to prejudgment interest,
162 the insured shall select whether to receive prejudgment interest
163 or interest under this subsection. Interest is payable when the
164 claim or portion of the claim is paid. Failure to comply with
165 this subsection constitutes a violation of this code. However,
166 failure to comply with this subsection does not form the sole
167 basis for a private cause of action.
168 Section 5. Section 627.7142, Florida Statutes, is amended
169 to read:
170 627.7142 Homeowner Claims Bill of Rights.—An insurer
171 issuing a personal lines residential property insurance policy
172 in this state must provide a Homeowner Claims Bill of Rights to
173 a policyholder within ~~14~~ 7 days after receiving an initial
174 communication with respect to a claim, unless the claim follows
175 an event that is the subject of a declaration of a state of
176 emergency by the Governor. The purpose of the bill of rights is
177 to summarize, in simple, nontechnical terms, existing Florida
178 law regarding the rights of a personal lines residential
179 property insurance policyholder who files a claim of loss. The
180 Homeowner Claims Bill of Rights is specific to the claims
181 process and does not represent all of a policyholder's rights
182 under Florida law regarding the insurance policy. The Homeowner

183 Claims Bill of Rights does not create a civil cause of action by
184 any individual policyholder or class of policyholders against an
185 insurer or insurers. The failure of an insurer to properly
186 deliver the Homeowner Claims Bill of Rights is subject to
187 administrative enforcement by the office but is not admissible
188 as evidence in a civil action against an insurer. The Homeowner
189 Claims Bill of Rights does not enlarge, modify, or contravene
190 statutory requirements, including, but not limited to, ss.
191 626.854, 626.9541, 627.70131, 627.7015, and 627.7074, and does
192 not prohibit an insurer from exercising its right to repair
193 damaged property in compliance with the terms of an applicable
194 policy or ss. 627.7011(5)(e) and 627.702(7). The Homeowner
195 Claims Bill of Rights must state:

196 HOMEOWNER CLAIMS
197 BILL OF RIGHTS
198 This Bill of Rights is specific to the claims process and does
199 not represent all of your rights under Florida law regarding
200 your policy. There are also exceptions to the stated timelines
201 when conditions are beyond your insurance company's control.
202 This document does not create a civil cause of action by an
203 individual policyholder, or a class of policyholders, against an
204 insurer or insurers and does not prohibit an insurer from
205 exercising its right to repair damaged property in compliance
206 with the terms of an applicable policy.

207 YOU HAVE THE RIGHT TO:

208 1. Receive from your insurance company an acknowledgment
209 of your reported claim within ~~14~~ 7 days after the time you
210 communicated the claim.
211 2. Upon written request, receive from your insurance
212 company within ~~30~~ 15 days after you have submitted a
213 complete proof-of-loss statement to your insurance company,
214 confirmation that your claim is covered in full, partially
215 covered, or denied, or receive a written statement that
216 your claim is being investigated.
217 3. Within ~~90~~ 45 days, subject to any dual interest noted
218 in the policy, receive full settlement payment for your
219 claim or payment of the undisputed portion of your claim,
220 or your insurance company's denial of your claim.
221 4. Free mediation of your disputed claim by the Florida
222 Department of Financial Services, Division of Consumer
223 Services, under most circumstances and subject to certain
224 restrictions.
225 5. Neutral evaluation of your disputed claim, if your
226 claim is for damage caused by a sinkhole and is covered by
227 your policy.
228 6. Contact the Florida Department of Financial Services,
229 Division of Consumer Services' toll-free helpline for
230 assistance with any insurance claim or questions pertaining
231 to the handling of your claim. You can reach the Helpline
232 by phone at...(toll-free phone number)..., or you can seek
233 assistance online at the Florida Department of Financial

234 Services, Division of Consumer Services' website
235 at...(website address)....

236 YOU ARE ADVISED TO:
237 1. Contact your insurance company before entering into any
238 contract for repairs to confirm any managed repair policy
239 provisions or optional preferred vendors.
240 2. Make and document emergency repairs that are necessary
241 to prevent further damage. Keep the damaged property, if
242 feasible, keep all receipts, and take photographs of damage
243 before and after any repairs.
244 3. Carefully read any contract that requires you to pay
245 out-of-pocket expenses or a fee that is based on a
246 percentage of the insurance proceeds that you will receive
247 for repairing or replacing your property.
248 4. Confirm that the contractor you choose is licensed to
249 do business in Florida. You can verify a contractor's
250 license and check to see if there are any complaints
251 against him or her by calling the Florida Department of
252 Business and Professional Regulation. You should also ask
253 the contractor for references from previous work.
254 5. Require all contractors to provide proof of insurance
255 before beginning repairs.
256 6. Take precautions if the damage requires you to leave
257 your home, including securing your property and turning off
258 your gas, water, and electricity, and contacting your
259 insurance company and provide a phone number where you can

260 be reached.

261 Section 6. This act shall take effect July 1, 2015.

262

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 895 Flood Insurance
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1094

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

SUMMARY ANALYSIS

The National Flood Insurance Program (NFIP) is a federal program that offers federally-subsidized flood insurance to property owners and promotes land-use controls in floodplains. The Federal Emergency Management Agency (FEMA) administers the NFIP. The Biggert-Waters Flood Insurance Reform Act of 2012 (BW-12) made major changes to the NFIP, including an increase in rates charged by the NFIP for flood insurance, starting in 2013. However, starting October 1, 2013, some NFIP policies that were subsidized moved directly to full-risk rates, resulting in dramatic flood insurance rate increases for some homeowners. In March 2014, federal legislation was enacted to moderate some of the rate increases resulting from BW-12.

In 2014, the Legislature enacted s. 627.715, F.S., to provide a framework for a private, personal lines flood insurance market in Florida. The section provides for four types of flood insurance: *standard flood insurance* (which is equivalent to a standard policy under the NFIP), *preferred flood insurance, customized flood insurance*, and *supplemental flood insurance*. The section allows insurers to develop rates for flood coverage, by either filing the rate with the Office of Insurance Regulation (OIR) and obtaining approval, or, until October 1, 2019, use a rate without OIR approval, so long as the rate is not excessive, inadequate, or unfairly discriminatory. Additionally, surplus lines insurers are permitted (until July 1, 2017) to offer primary flood coverage without the agent having to obtaining three declinations from authorized insurers.

The proposed committee substitute (PCS):

- Creates a fifth type of flood insurance under s. 627.715, F.S., called "flexible flood insurance," which is defined as the coverage for the peril of flood that may include water intrusion coverage, and includes or excludes specified provisions.
- Requires that flexible flood policies must be acceptable to the mortgage lender if such policy, contract, or endorsement is intended to satisfy a mortgage requirement.
- Clarifies the definition of supplemental insurance to permit coverage in excess over any other insurance covering the peril of flood.
- Provides that the notice that insurance agents must provide to potential insureds must notify the applicant that the full risk rate may apply, if NFIP coverage at a subsidized rate is discontinued.
- Authorizes OIR to require insurers to provide appropriate return of premium to affected insureds, if the OIR determines a rate is excessive or unfairly discriminatory,
- Allows an insurer to request a certification from OIR that acknowledges that a private flood policy equals or exceeds the coverage offered by NFIP. Subject to OIR's verification that such policy is NFIP-equivalent, these certifications may be used in advertising and communications with agents, lenders, insureds, and potential insureds. The PCS provides that an insurer or agent who knowingly misrepresents that a flood policy, contract, or endorsement is certified commits an unfair and deceptive act.

The PCS does not have a fiscal impact on state or local governments, and may have a positive impact on the private sector.

The PCS provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

National Flood Insurance Program

The National Flood Insurance Program (NFIP or program) was created by the passage of the National Flood Insurance Act of 1968 to offer federally-subsidized flood insurance to property owners and to promote land-use controls in floodplains. The NFIP is administered by the Federal Emergency Management Agency (FEMA). The federal government will make flood insurance available within a community, if that community adopts and enforces a floodplain management ordinance to reduce future flood risk to new construction in floodplains.[1]

Nationally, the NFIP provided flood insurance coverage for 5.8 million properties and insured more than $1.3 trillion in assets in 2013.[2] Total earned premium for NFIP coverage for 2012 was $3.5 trillion.

Federal Requirements to Obtain NFIP Flood Insurance

In 1973 the U.S. Congress passed the Flood Disaster Protection Act.[3] The Act required property owners with mortgages issued by federally regulated or insured lenders to purchase flood insurance if their property was located in a Special Flood Hazard Area. Special Flood Hazard Areas are defined by FEMA as high-risk areas where there is at least a 1 in 4 chance of flooding during a 30-year mortgage.

The National Flood Insurance Reform Act of 1994[4] (1994 Reform Act) required federal financial regulatory agencies[5] to revise their flood insurance regulations. The 1994 Reform Act also applied flood insurance requirements to loans purchased by the Federal National Mortgage Association (Fannie Mae) and the Federal Home Loan Mortgage Corporation (Freddie Mac) and to agencies that provide government insurance or guarantees, such as the Small Business Administration, the Federal Housing Administration, and the Veterans Administration.[6]

The 1994 Reform Act prohibits federally regulated lending institutions from offering loans on properties located in a Special Flood Hazard Area of a community participating in the NFIP, unless the property is covered by flood insurance.[7] The minimum amount of NFIP flood insurance required by the 1994 Reform Act must be *at least* equal to the outstanding principal balance of the loan, or the maximum amount available under the NFIP, whichever is less.[8] This minimum standard also applies to private flood insurance accepted in lieu of NFIP flood insurance.[9] These provisions do not apply to state-owned property covered under an adequate state self-insurance policy satisfactory to FEMA, or to small loans (defined as having an original outstanding principal balance of $5,000 or less and a repayment term of one year or less).[10]

---

[1] FEMA, *National Flood Insurance Program, Program Description*, (Aug. 1, 2002), https://www.fema.gov/media-library/assets/documents/1150?id=1480 (last viewed Mar. 16, 2015)
[2] All 2013 NFIP statistics are available at http://www.fema.gov/statistics-calendar-year (last viewed Mar. 16, 2015).
[3] These statutes are codified at 42 U.S.C. §§4001-4129.
[4] Title V of the Riegle Community Development and Regulatory Improvement Act of 1994. Pub. L. 103-325, Title V, 108 Stat. 2160, 2255-87 (September 23, 1994).
[5] The federal financial regulators are the Office of Comptroller of Currency, the Federal Deposit Insurance Corporation, the National Credit Union Administration, the Farm Credit Administration, and the Board of Governors of the Federal Reserve System.
[6] *FDIC Compliance Manual*, V – 6.1. http://www.fdic.gov/regulations/compliance/manual/index.html (last viewed Mar. 16, 2015).
[7] 42 U.S.C §4012a(b).
[8] 42 U.S.C. §4012a(b)(1)(A).
[9] 42 U.S.C. §4012a(b)(1)(B).
[10] 42 U.S.C. §4012a(c).

For properties located outside Special Flood Hazard Areas, lenders on their own initiative may require flood insurance to be purchased to protect their investment. Additionally, it is noted that Federal Housing Administration, a federal mortgage insurer, is authorized to require flood insurance coverage higher than the NFIP minimum requirement on FHA-guaranteed mortgages, under the authority of the federal Housing Act.[11]

Standard NFIP Flood Insurance Policies

The standard flood insurance policy dwelling form offered by the NFIP[12] is a single peril flood policy that pays for direct physical damage to the insured residential property up to the replacement cost[13] (RCV) or actual cash value (ACV) or the policy limit.[14] The maximum coverage limit for a NFIP standard residential flood insurance policy is $250,000.[15] The NFIP also offers up to $100,000 in personal property (contents) coverage for residential property, which is always paid at ACV.[16]

The maximum coverage available to a condominium association purchased to cover the condominium building, the common and individually owned building elements within the condominium units, improvements within the units, and contents owned in common is $250,000 per unit multiplied by the total number of units, or the replacement cost of the condominium building, whichever is less.[17] Individual condominium unit owners can purchase flood insurance through the NFIP to insure contents in their condominium unit with a separate dwelling form policy. The NFIP flood insurance coverage limits on non-residential buildings are $500,000 in coverage to the building and $500,000 in contents coverage.[18] Properties that cannot obtain flood insurance through the NFIP or need more coverage (called excess coverage) than that provided by the NFIP can purchase flood insurance from licensed Florida insurers in the admitted market or surplus lines insurers,[19] although availability may be limited.

Most NFIP policies also include increased cost of compliance coverage of up to $30,000 per building for the increased cost to elevate, demolish, or relocate a building to comply with state or community floodplain management laws or ordinances after a flood which substantially damages or repetitively damages the building.[20]

---

[11] *Feaz v. Wells Fargo Bank, N.A.*, 745 F.3d 1098 (11th C.A. 2014). The Housing Act confers on the Secretary of the U.S. Department of Housing and Urban Development the authority to prescribe terms for FHA-insured mortgage contracts, such as mandatory covenants requiring a FHA borrower to maintain hazard and flood insurance in amounts required by the lender. In *Feaz*, the Eleventh Circuit interpreted a FHA covenant to permit the lender to require flood coverage above the NFIP minimum (i.e., the lesser of the loan's principal balance or the NFIP maximum of $250,000), to require the lesser of the home's replacement value or $250,000.

[12] The standard form insures one-to-four family residential buildings and single-family dwelling units in a condominium building. The NFIP also offers (a) a general property form that is used to insure five-or-more-family residential buildings and non-residential buildings and (b) a residential condominium building association policy form that insures residential condominium association buildings. *National Flood Insurance Program: Summary of Coverage*, Federal Emergency Management Agency (FEMA F-679/November 2012), http://www.fema.gov/media-library-data/20130726-1620-20490-4648/f_679_summaryofcoverage_11_2012.pdf (last viewed Mar. 16, 2015).

[13] To obtain RCV coverage under the NFIP dwelling form, the building must be a single-family dwelling, be the principal residence of the insured at the time of loss (the insured lives there at least 80 percent of the year), and the building coverage of at least 80 percent of the full replacement cost of the building or its the maximum available for the property under the NFIP.

[14] *National Flood Insurance Program: Summary of Coverage*, Federal Emergency Management Agency (FEMA F-679/November 2012) http://www.fema.gov/media-library-data/20130726-1620-20490-4648/f_679_summaryofcoverage_11_2012.pdf (last viewed Mar. 16, 2015).

[15] 44 C.F.R. §61.6.

[16] *Id.*

[17] 44 C.F.R. §61.6(b).

[18] 44 C.F.R. §61.6.

[19] Unlike insurers in the admitted market, surplus lines insurers are not licensed insurers, do not have their rates regulated by the Office of Insurance Regulation, and do not participate in the Florida Insurance Guaranty Association.

[20] The total amount of a building claim and an increased cost of coverage claim cannot exceed the maximum limit for building property coverage. For a single-family home, this is $250,000. The limit is $500,000 for non-residential structures. See *National Flood Insurance Program: Summary of Coverage*, Federal Emergency Management Agency (FEMA F-679/November 2012).

NFIP flood policies have separate deductibles for building and personal property (contents) coverage, so a policyholder could pay two deductibles if a loss occurs. Generally, for most properties built before the effective date of the first flood insurance rate map[21] for a community, the minimum deductible[22] is:

- $1,000 if the property is located in certain flood zones.
- $2,000 if the property is located in other flood zones.

For most properties built after the effective date of the first flood insurance rate map for a community, the minimum deductible is $1,000 if the property is insured in any flood zone.[23]

Generally, deductibles for most NFIP residential policies can increase in $1,000 increments from the required minimum, with the maximum deductible being $5,000 for building coverage and $5,000 for contents coverage.[24]

The Biggert-Waters Flood Insurance Reform Act of 2012

Following flood losses from the 2005 hurricanes Katrina, Rita, and Wilma, the NFIP borrowed $21 billion from the U.S. Treasury in order to remain solvent. However, flood losses in 2012 from Superstorm Sandy increased the NFIP's deficit. In 2012, the United States Congress passed the Biggert-Waters Flood Insurance Reform Act (Biggert-Waters Act).[25] The Biggert-Waters Act reauthorized the National Flood Insurance Program for 5 years. Key provisions of the legislation require the NFIP to raise rates to reflect true flood risk, make the program more financially stable, and change how Flood Insurance Rate Map updates impact policyholders. These changes by Congress have resulted in premium rate increases for approximately 20 percent of NFIP policyholders nationwide.

The Biggert-Waters Act increases flood insurance premiums purchased through the program for second homes, business properties, severe repetitive loss properties, and substantially improved damaged properties by requiring premium increases of 25 percent per year until premiums meet the full actuarial cost of flood coverage. Most residences immediately lose their subsidized rates if the property is sold, the policy lapses, repeated and severe flood losses occur, or a new policy is purchased. Some flood maps used by FEMA have not been updated since the 1980s. Policyholders whose communities adopt a new, updated Flood Insurance Rate Map (FIRM) that results in higher rates will experience a 5-year phase in of rate increases to achieve rates that incorporate the full actuarial cost of coverage.

The Reform Act also requires most NFIP policyholders to pay a 5% assessment on their policy to create a reserve fund for catastrophic losses.[26] Additional changes to premium rates, including those paid by the 80

---

http://www.fema.gov/media-library-data/20130726-1620-20490-4648/f_679_summaryofcoverage_11_2012.pdf (last viewed Jan. 23, 2015).

[21] The effective date of the first flood insurance rate map (FIRM) for Florida communities can be found at http://www.fema.gov/cis/FL.pdf (last viewed Mar. 16, 2015); *National Flood Insurance Program Flood Insurance Manual*, RATE 16, Federal Emergency Management Agency (Revised Oct. 2013), http://www.fema.gov/media-library/assets/documents/34745 (last viewed Mar. 16, 2015).

[22] The minimum deductible for properties located in any flood zone in the NFIP emergency program is $2,000. The minimum deductible for pre-FIRM properties with optional post-FIRM elevation ratings in any flood zone is $1,000. See *National Flood Insurance Program Flood Insurance Manual*, RATE 14, Federal Emergency Management Agency (Revised October 2013) . http://www.fema.gov/media-library/assets/documents/34745 (last viewed Mar. 16, 2015).

[23] *National Flood Insurance Program Flood Insurance Manual*, RATE 14, Federal Emergency Management Agency (Revised October 2013). http://www.fema.gov/media-library/assets/documents/34745 (last viewed Mar. 16, 2015).

[24] For a full listing of NFIP deductible options, see *National Flood Insurance Program Flood Insurance Manual*, RATE 14-RATE 15, Federal Emergency Management Agency (Revised October 2013). http://www.fema.gov/media-library/assets/documents/34745 (last viewed Mar. 16, 2015). Deductibles for non-residential flood policies can increase to $50,000 for building and $50,000 for contents coverage.

[25] FEMA, Flood Insurance Reform, https://www.fema.gov/national-flood-insurance-program/flood-insurance-reform (last viewed Mar. 16, 2015).

[26] For those NFIP policies with a 25% rate increase, the 5% assessment is not on top of the 25% rate increase. In other words, 5% of the 25% increase will be allocated to the Reserve Fund.

percent of NFIP policyholders with non-subsidized rates, can occur upon remapping. Current law limits rate increases due to remapping to 10 percent per year, so Biggert-Waters allows a larger annual rate increase for remapped properties. However, federal action in the 2014 federal omnibus spending bill has likely delayed rate increases associated with remapping for 12-18 months, as described below.

2014 Federal Flood Reform Bills

The Consolidated Appropriations Act of 2014 and the Homeowner Flood Insurance Affordability Act of 2014[27] repealed or modified some provisions of the Biggert-Waters Act. The new law reduced the rate mandatory rate increases for subsidized properties from 25% annually to no less than 5%, generally not to increase more than 18% annually.[28] Properties that remain subject to the 25 percent annual increase include older business properties, older non-primary residences, severe repetitive loss properties, and pre-FIRM properties. The 20% annual phase-in of premium increases after adoption of a new or updated flood insurance rate map was reduced to a maximum of no more than an 18% annual premium increase. For property not currently at a full-risk rate, a minimum increase of 5% per year is required for flood policies on primary residences built on or before December 31, 1994 or before the effective date of the initial flood insurance rate map for the community was adopted.[29]

The policyholder refunds were provided to policyholders whose rate increases were revised by the 2014 changes. Additional revisions included increasing the maximum flood insurance deductibles, directing FEMA to consider property specific flood mitigation in determining a full-risk rate, and creating the position of a Flood Insurance Advocate.

NFIP Flood Insurance in Florida

Over two million NFIP policies are written on Florida properties, with approximately 268,500 policies receiving subsidized rates. This accounts for approximately 37% of the total flood policies written by the NFIP, more than any other state.[30] Eighty-seven percent of the 2 million Florida policies (1.78 million policies) have nonsubsidized rates, so will not be subject to the 25% annual rate increases under Biggert-Waters. These policies, however, may see routine annual rate increases and rate increases of up to 20% per year, due to re-mapping after FEMA is allowed to spend funds on remapping.

From 1987-2008, the NFIP collected $3.60 in Florida premiums for every $1 paid in claims to Florida.[31] The rate impact of the Biggert-Waters Act on subsidized policies in Florida is approximately as follows:

- Approximately 50,000 secondary residences, businesses, and severe repetitive loss properties are subject to immediate, annual 25 percent increases until their premiums are full risk premiums.
- Approximately 103,000 primary residences will lose their subsidy if the property is sold, the policy lapses, if the property suffers severe, repeated flood losses, or if a new policy is purchased.
- Approximately 115,000 non-primary residences, business properties, and severe repetitive loss properties are subject to the elimination of subsidies once FEMA develops guidance for their removal.

[27] Homeowner Flood Insurance Affordability Act of 2014, H.R. 3370, 113th Cong. (2014) (Pub. L. No. 113-89).
[28] FEMA, *Homeowner Flood Insurance Affordability Act Overview*, https://www.fema.gov/media-library/assets/documents/93074 (last viewed Mar. 16, 2015).
[29] FN 27, at section 5.
[30] Florida NFIP statistics contained in this and the following paragraphs are from the House Insurance & Banking Subcommittee meeting materials for the September 25, 2013 meeting.
[31] Wharton Center for Risk Management and Decision Processes, Issue Brief, Fall 2011 – "Who's paying and who's benefiting most from flood insurance under the NFIP? A Financial Analysis of the US. National Flood Insurance Program," opim.wharton.upenn.edu/risk/library/WRCib2011b-nfip-who-pays.pdf (last viewed Mar. 16, 2015).

Private Market Flood Insurance in Florida

The 2014 Legislature enacted s. 627.715, F.S., governing the sale of personal lines, residential flood insurance.[32] Flood is defined in the standard NFIP policy as a general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties from:

- Overflow of inland or tidal waters;
- Unusual and rapid accumulation or runoff of surface waters from any source;
- Mudflow; or
- Collapse or subsidence of land along the shore of a lake or similar body of water as a result of erosion or undermining caused by waves or currents of water exceeding anticipated cyclical levels that result in a flood as defined above.

Authorized insurers may sell four different types of flood insurance products:

- Standard coverage, which covers only losses from the peril of flood as defined in the bill, which is the definition used by the National Flood Insurance Program (NFIP). The policy must be the same as coverage offered from the NFIP regarding the definition of flood, coverage, deductibles, and loss adjustment.
- Preferred coverage, which includes the same coverage as standard flood insurance and also must cover flood losses caused by water intrusion from outside the structure that are not otherwise covered under the definition of flood in the bill.
- Customized coverage, which is coverage that is broader than standard flood coverage.
- Supplemental coverage, which supplements an NFIP flood policy or a standard or preferred policy from a private market insurer. Supplemental coverage may provide coverage for jewelry, art, deductibles, and additional living expenses. It does not include excess flood coverage over other flood policies.

Insurers must provide prominent notice on the policy declarations or face page of deductibles and any other limitations on flood coverage or policy limits. Insurance agents that receive a flood insurance application must obtain a signed acknowledgement from the applicant stating that the full risk rate for flood insurance may apply to the property if flood insurance is later obtained under the NFIP.

An insurer may establish flood rates through the standard process in s. 627.062, F.S. Alternatively, rates filed before October 1, 2019, may be established through a rate filing with the Office of Insurance Regulation (OIR) that is not required to be reviewed by the OIR before implementation of the rate ("file and use" review) or shortly after implementation of the rate ("use and file" review). Specifically, the flood rate is exempt from the "file and use" and "use and file" requirements of s. 627.062(2)(a), F.S. Such filings are also exempt from the requirement to provide information necessary to evaluate the company and the reasonableness of the rate. The OIR may, however, examine a rate filing at its discretion. To enable the office to conduct such examinations, insurers must maintain actuarial data related to flood coverage for 2 years after the effective date of the rate change. Upon examination, the OIR will use actuarial techniques and the standards of the rating law to determine if the rate is excessive, inadequate or unfairly discriminatory. The law allows projected flood losses for personal residential property insurance to be a rating factor. Flood losses may be estimated using a model or straight average of models found reliable by the Florida Commission on Hurricane Loss Projection Methodology.

Insurers that write flood coverage must notify the OIR at least 30 days before doing so in this state and file a plan of operation, financial projections, and any such revisions with the OIR. Surplus lines agents may export flood insurance without making a diligent effort to seek coverage from three or more authorized insurers until July 1, 2017. Citizens Property Insurance Corporation is prohibited from providing flood insurance and the Florida Hurricane Catastrophe Fund is prohibited from reimbursing flood losses.

[32] Ch. 2014-80, Laws of Fla.

Effect of the Proposed Committee Substitute (PCS)

The Proposed Committee Substitute (PCS) amends s. 627.715, F.S., to allow insurers to sell flexible flood insurance, which is defined as coverage for the peril of flood that may include water intrusion coverage and differs from standard or preferred coverage by:

- Including a deductible as authorized in s. 627.701, F.S.
- Being adjusted in accordance with s. 627.7011(3), F.S.
- Covering only the principal building, as defined in the policy.
- Including or excluding coverage for additional living expenses.
- Excluding coverage for personal property or contents.

Flexible flood coverage must be acceptable to the mortgage lender if it is intended to satisfy a mortgage requirement.

The section removes language in statute that specifies a supplemental flood insurance policy does not include flood coverage for the purpose of excess coverage over any other insurance policy covering the peril of flood. Removing this language from law could allow a supplemental flood insurance policy to provide coverage in excess of other coverage that is insuring for the peril of flood.

The PCS also clarifies the signed acknowledgement that a licensed insurance agent must obtain notifying the applicant about the potential loss of subsidized rates when discontinuing coverage from the NFIP. The notice is revised to specify that the policyholders who might lose subsidies are those who have subsidized NFIP policies.

Lastly, the section allows an insurer to request from OIR a certification that acknowledges that the insurer provides a policy, contract, or endorsement for the flood insurance that provides coverage equaling or exceeding the flood coverage offered by the NFIP. A certified policy must be in compliance with 42 U.S.C. s. 1042a(b), which requires federally regulated lending institutions to accept private flood insurance that insures the building and personal property securing the loan for the term of the loan in an amount not less than the outstanding principal balance of the loan or the limit of NFIP flood insurance coverage, whichever is less. Subject to OIR's verification that the policy is NFIP-equivalent, an insurer or its agent may reference or include such certification in advertising and communications with an agent, a lending institution, an insured, and a potential insured. The authorized insurer may also include a statement that notifies an insured of the certification on the declarations page or other policy documentation related to flood coverage. A knowing misrepresentation that a flood insurance policy is certified is an unfair or deceptive act.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.715, F.S., relating to flood insurance.

Section 2. Provides an effective date of July 1, 2015.

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:

To the extent that the PCS encourages more private insurers to provide coverage for flood loss, consumers may ultimately benefit from increased competition.

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

1 A bill to be entitled
2 An act relating to flood insurance; amending s.
3 627.715, F.S.; authorizing flexible flood insurance;
4 specifying coverage requirements; requiring such
5 insurance to be acceptable to the mortgage lender if
6 intended to satisfy a mortgage requirement; deleting a
7 provision that prohibits supplemental flood insurance
8 from including excess coverage over any other
9 insurance covering the peril of flood; revising the
10 information that must be prominently noted on a
11 certain page of a flood insurance policy; requiring
12 the Office of Insurance Regulation to require an
13 insurer to provide appropriate return of premium to
14 affected insureds if the office determines that a rate
15 of the insurer is excessive or unfairly
16 discriminatory; revising the notice that must be
17 provided to and acknowledged by an applicant for flood
18 coverage from an authorized or surplus lines insurer
19 if the applicant's property is receiving flood
20 insurance under the National Flood Insurance Program;
21 allowing an authorized insurer to request a
22 certification from the office which indicates that a
23 policy, contract, or endorsement issued by the insurer
24 provides coverage for the peril of flood which equals
25 or exceeds the flood coverage offered by the National
26 Flood Insurance Program; specifying requirements for

27 such certification; authorizing such insurer or its
28 agent to reference or include the certification in
29 specified advertising, communications, and
30 documentation; providing that misrepresenting that a
31 flood policy, contract, or endorsement is certified is
32 an unfair or deceptive act; providing an effective
33 date.
34
35 Be It Enacted by the Legislature of the State of Florida:
36
37 Section 1. Section 627.715, Florida Statutes, is amended
38 to read:
39 627.715 Flood insurance.—An authorized insurer may issue
40 an insurance policy, contract, or endorsement providing personal
41 lines residential coverage for the peril of flood on any
42 structure or the contents of personal property contained
43 therein, subject to this section. This section does not apply to
44 commercial lines residential or commercial lines nonresidential
45 coverage for the peril of flood. This section also does not
46 apply to coverage for the peril of flood that is excess coverage
47 over any other insurance covering the peril of flood. An insurer
48 may issue flood insurance policies, contracts, or endorsements
49 on a standard, preferred, customized, or supplemental basis.
50 (1)(a)1. Standard flood insurance must cover only losses
51 from the peril of flood, as defined in paragraph (b), equivalent
52 to that provided under a standard flood insurance policy under

53 the National Flood Insurance Program. Standard flood insurance
54 issued under this section must provide the same coverage,
55 including deductibles and adjustment of losses, as that provided
56 under a standard flood insurance policy under the National Flood
57 Insurance Program.
58 2. Preferred flood insurance must include the same
59 coverage as standard flood insurance but:
60 a. Include, within the definition of "flood," losses from
61 water intrusion originating from outside the structure that are
62 not otherwise covered under the definition of "flood" provided
63 in paragraph (b).
64 b. Include coverage for additional living expenses.
65 c. Require that any loss under personal property or
66 contents coverage that is repaired or replaced be adjusted only
67 on the basis of replacement costs up to the policy limits.
68 3. Customized flood insurance must include coverage that
69 is broader than the coverage provided under standard flood
70 insurance.
71 4. Flexible flood insurance must cover losses from the
72 peril of flood, as defined in paragraph (b), and may also
73 include coverage for losses from water intrusion originating
74 from outside the structure which is not otherwise covered by the
75 definition of flood. Flexible flood insurance must include one
76 or more of the following provisions:
77 a. A deductible in an amount authorized and subject to the
78 requirements of s. 627.701, including a deductible in an amount

79 authorized for hurricanes.
80 b. A requirement that flood loss to a dwelling or personal
81 property be adjusted in accordance with s. 627.7011(3).
82 c. A restriction limiting flood coverage to the principal
83 building defined in the policy.
84 d. A provision including or excluding coverage for
85 additional living expenses.
86 e. A provision excluding coverage for personal property or
87 contents as to the peril of flood.
88
89 Flexible flood insurance must be acceptable to the mortgage
90 lender if such policy, contract, or endorsement is intended to
91 satisfy a mortgage requirement.
92 5.~~4.~~ Supplemental flood insurance may provide coverage
93 designed to supplement a flood policy obtained from the National
94 Flood Insurance Program or from an insurer issuing standard or
95 preferred flood insurance pursuant to this section. Supplemental
96 flood insurance may provide, but need not be limited to,
97 coverage for jewelry, art, deductibles, and additional living
98 expenses. ~~Supplemental flood insurance does not include coverage~~
99 ~~for the peril of flood that is excess coverage over any other~~
100 ~~insurance covering the peril of flood.~~
101 (b) "Flood" means a general and temporary condition of
102 partial or complete inundation of two or more acres of normally
103 dry land area or of two or more properties, at least one of
104 which is the policyholder's property, from:

105 1. Overflow of inland or tidal waters;
106 2. Unusual and rapid accumulation or runoff of surface
107 waters from any source;
108 3. Mudflow; or
109 4. Collapse or subsidence of land along the shore of a
110 lake or similar body of water as a result of erosion or
111 undermining caused by waves or currents of water exceeding
112 anticipated cyclical levels that result in a flood as defined in
113 this paragraph.
114 (2) Any limitations on Flood coverage or policy limits
115 pursuant to this section, including, but not limited to,
116 deductibles, must be prominently noted on the policy
117 declarations page or face page.
118 (3)(a) An insurer may establish and use flood coverage
119 rates in accordance with the rate standards provided in s.
120 627.062.
121 (b) For flood coverage rates filed with the office before
122 October 1, 2019, the insurer may also establish and use such
123 rates in accordance with the rates, rating schedules, or rating
124 manuals filed by the insurer with the office which allow the
125 insurer a reasonable rate of return on flood coverage written in
126 this state. Flood coverage rates established pursuant to this
127 paragraph are not subject to s. 627.062(2)(a) and (f). An
128 insurer shall notify the office of any change to such rates
129 within 30 days after the effective date of the change. The
130 notice must include the name of the insurer and the average

131 statewide percentage change in rates. Actuarial data with regard
132 to such rates for flood coverage must be maintained by the
133 insurer for 2 years after the effective date of such rate change
134 and is subject to examination by the office. The office may
135 require the insurer to incur the costs associated with an
136 examination. Upon examination, the office, in accordance with
137 generally accepted and reasonable actuarial techniques, shall
138 consider the rate factors in s. 627.062(2)(b), (c), and (d), and
139 the standards in s. 627.062(2)(e), to determine if the rate is
140 excessive, inadequate, or unfairly discriminatory. If the office
141 determines that a rate is excessive or unfairly discriminatory,
142 the office shall require the insurer to provide appropriate
143 return of premium to affected insureds.
144 (4) A surplus lines agent may export a contract or
145 endorsement providing flood coverage to an eligible surplus
146 lines insurer without making a diligent effort to seek such
147 coverage from three or more authorized insurers under s.
148 626.916(1)(a). This subsection expires July 1, 2017.
149 (5) In addition to any other applicable requirements, an
150 insurer providing flood coverage in this state must:
151 (a) Notify the office at least 30 days before writing
152 flood insurance in this state; and
153 (b) File a plan of operation and financial projections or
154 revisions to such plan, as applicable, with the office.
155 (6) Citizens Property Insurance Corporation may not
156 provide insurance for the peril of flood.

157 (7) The Florida Hurricane Catastrophe Fund may not provide
158 reimbursement for losses proximately caused by the peril of
159 flood, including losses that occur during a covered event as
160 defined in s. 215.555(2)(b).

161 (8) An agent must, upon receiving ~~obtaining~~ an application
162 for flood coverage from an authorized or surplus lines insurer
163 for a property receiving flood insurance under the National
164 Flood Insurance Program, ~~must~~ obtain an acknowledgment signed by
165 the applicant before placing the coverage with the authorized or
166 surplus lines insurer. The acknowledgment must notify the
167 applicant that, if the applicant discontinues coverage under the
168 National Flood Insurance Program which is provided at a
169 subsidized rate, the full risk rate for flood insurance may
170 apply to the property if the applicant ~~such insurance is~~ later
171 seeks to reinstate coverage ~~obtained~~ under the ~~National Flood~~
172 ~~Insurance~~ program.

173 (9) With respect to the regulation of flood coverage
174 written in this state by authorized insurers, this section
175 supersedes any other provision in the Florida Insurance Code in
176 the event of a conflict.

177 (10) If federal law or rule requires a certification by a
178 state insurance regulatory official as a condition of qualifying
179 for private flood insurance or disaster assistance, the
180 Commissioner of Insurance Regulation may provide the
181 certification, and such certification is not subject to review
182 under chapter 120.

183 (11)(a) An authorized insurer offering flood insurance may
184 request the office to certify that a policy, contract, or
185 endorsement provides coverage for the peril of flood which
186 equals or exceeds the flood coverage offered by the National
187 Flood Insurance Program. To be eligible for certification, such
188 policy, contract, or endorsement must state, and the office must
189 confirm, that it meets the private flood insurance requirements
190 specified in 42 U.S.C. s. 4012a(b) and may not contain any
191 provision that is not in compliance with 42 U.S.C. s. 4012a(b).
192 (b) The authorized insurer or its agent may reference or
193 include a certification under paragraph (a) in advertising or
194 communications with an agent, a lending institution, an insured,
195 or a potential insured only for a policy, contract, or
196 endorsement that is certified under this subsection. The
197 authorized insurer may include a statement that notifies an
198 insured of the certification on the declarations page or other
199 policy documentation related to flood coverage certified under
200 this subsection.
201 (c) An insurer or agent who knowingly misrepresents that a
202 flood policy, contract, or endorsement is certified under this
203 subsection commits an unfair or deceptive act under s. 626.9541.
204 Section 2. This act shall take effect July 1, 2015.
205

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1013 Maximum Reimbursement Allowances for Workers' Compensation Medical Services
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

The Department of Financial Services (DFS) adopts rules establishing the policies and processes governing the provision, billing, and reimbursement of medical services under Florida's Workers' Compensation Law. Those rules include the maximum reimbursement allowances approved by a three-member panel. The three-member panel is composed of the Chief Financial Officer of the State of Florida (CFO), or the CFO's designee, and a representative of employers and a representative of employees. The Governor's appointees must be confirmed by the Senate. The DFS, in cooperation with and support of the three-member panel, adopts a series of reimbursement manuals related to workers' compensation medical services. There are three such reimbursement manuals; one each for individual health care providers, hospitals, and ambulatory surgical centers. The reimbursement manuals incorporate the maximum reimbursement allowances approved by the three-member panel. Whenever the three-member panel approves revised maximum reimbursement allowances, which are required annually, a legislative ratification may be triggered when they are incorporated into a rule.

The Florida Administrative Procedure Act (APA) requires state agencies to assess whether a Statement of Estimated Regulatory Cost (SERC) must be prepared in conjunction with the promulgation of an administrative rule. The preparation of a SERC is required if a proposed rule will have an adverse impact on small business, or if it is likely to directly or indirectly increase regulatory costs by more than $200,000 within one year of implementation. If the SERC analysis indicates the rule is likely to have an aggregate economic impact exceeding $1 million in the first five years from implementation, then the rule must be ratified by the Legislature before going into effect. The APA requires that the rule be submitted to the President of the Senate and the Speaker of the House of Representatives no later than 30 days prior to the next regular legislative session, and the rule may not take effect until it is ratified by the Legislature.

In September 2011, the DFS adopted rule 69L-7.020, F.A.C., which incorporated a revised edition of the health care provider reimbursement manual, including the three-member panel's approved maximum reimbursement allowances. This rule change met the legislative ratification threshold. The rule was submitted to the Legislature for ratification in 2012 and has not been ratified to date. The DFS withdrew the 2011 rule change in February 2015 and began the rulemaking process to adopt an updated revised edition of the manual, including a new set of maximum reimbursement allowances approved by the three-member panel. The 2015 revision may be adopted, pending legislative ratification, during the 2015 Regular Session.

The PCS requires the DFS to adopt, by order, the maximum reimbursement allowances approved by the three-member panel. The DFS order will be subject to an administrative hearing and judicial review under the APA. The PCS does not impact the private sector. It has an indeterminate, but likely positive, impact on state government and no impact on local government.

The PCS is effective July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida's Workers' Compensation Law[1] requires employers to provide injured employees all medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require.[2] The Department of Financial Services, Division of Workers' Compensation (DFS), provides regulatory oversight of Florida's workers' compensation system. The law specifies certain reimbursement formulas and methodologies to compensate workers' compensation health care providers[3] that provide medical services to injured employees. Where a reimbursement amount or methodology is not specifically included in statute, the three-member panel is authorized to annually adopt statewide schedules of maximum reimbursement allowances (MRAs) to provide uniform fee schedules for the reimbursement of various medical services.[4] DFS incorporates the MRAs approved by the three-member panel in reimbursement manuals[5] through the rulemaking process provided by the Administrative Procedures Act.[6]

The Three-Member Panel

The three-member panel is created by statute to adopt MRAs and report on and make recommendations regarding the state of the workers' compensation health care delivery system.[7] The panel is made up of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members appointed by the Governor. The Governor's appointees are subject to confirmation by the Senate. One of the Governor's appointees is a representative of employers, while the other is a representative of employees.[8] The panel has approved three sets of MRAs. The MRAs establish the expected reimbursement amounts for medical services rendered by individual health care providers, hospitals, and ambulatory surgical centers. The three-member panel does not have rulemaking authority. The DFS is charged with providing administrative support to the three-member panel and implements the three-member panels MRA approvals through its rules. The three-member panel holds publicly noticed open meetings to implement their duties and obligations.

Reimbursement Manuals

The DFS periodically adopts rules implementing the administrative policies and procedures that govern the provision, billing, and reimbursement of medical services in the workers' compensation health care delivery system. There are three reimbursement manuals adopted by the DFS. They are the *Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2008 Edition*;[9] the *Florida Workers' Compensation Reimbursement Manual for Ambulatory Surgical Centers, 2011 Edition*;[10] and, the *Florida Workers' Compensation Reimbursement Manual for Hospitals, 2014 Edition.*[11] The DFS has rulemaking authority to develop the reimbursement manuals. The DFS can choose the organization of

---

[1] Chapter 440, F.S.
[2] Section 440.13(2)(a), F.S.
[3] The term "health care provider" includes a physician or any recognized practitioner licensed to provide skilled services pursuant to a prescription or under the supervision or direction of a physician. It also includes any hospital licensed under chapter 395 and any health care institution licensed under chapter 400 or chapter 429. Section 440.13(1)(g), F.S.
[4] Section 440.13(12), F.S.
[5] Subsections 440.13(12) and (13), F.S. Chapter 69L-7, F.A.C.
[6] Chapter 120, F.S.
[7] Section 440.13(12), F.S.
[8] Section 440.13(a), F.S.
[9] Rule 69L-7.020, F.A.C.
[10] Rule 69L-7.100, F.A.C.
[11] Rule 69L-7.501, F.A.C.

their rules and currently incorporates each set of MRAs into the related reimbursement manual as a single document. In the alternative, the DFS could choose to adopt two sets of rules, one set that establishes the processes for provision and billing of medical services and another set to deliver the three-member panel's approved MRAs.

Each of the reimbursement manuals incorporates one of the three sets of MRAs. The DFS incorporates the MRAs into the reimbursement manuals as those manuals proceed through the APA's rulemaking process. The DFS analyses the economic impact of the entire reimbursement manual to identify whether the legislative ratification threshold is met. However, the three-member panel's revisions to the MRAs are typically the cost driver in this analysis and can trigger ratification because of the significant economic impact that uniform changes to provider reimbursements can create.

In September 2011, the Department adopted Rule 69L-7.020, F.A.C., adopting the 2011 Edition of the health care provider reimbursement manual. The approved MRAs that were included in the manual were estimated to have an economic impact in excess of the legislative ratification threshold. The rule was not ratified by the Legislature in the 2012, 2013, or 2014 Regular Sessions. In 2013, HB 1165 was filed, to ratify the rule. HB 1165 was not considered and no other bills were filed for this purpose during these sessions. In February 2015, the DFS withdrew the rule development that adopted the 2011 Edition, pending legislative ratification. The DFS also proposed an updated edition, including a new set of MRAs approved by the three-member panel.[12]

Rulemaking Authority and Legislative Ratification

A rule is an agency statement of general applicability that interprets, implements, or prescribes law or policy, including the procedure and practice requirements of an agency, as well as certain types of forms.[13] Rulemaking authority is delegated by the Legislature[14] through statute and authorizes an agency to "adopt, develop, establish, or otherwise create"[15] a rule. Agencies do not have discretion whether to engage in rulemaking.[16] To adopt a rule, an agency must have a general grant of authority to implement a specific law by rulemaking.[17] The grant of rulemaking authority itself need not be detailed.[18] The specific statute being interpreted or implemented through rulemaking must provide specific standards and guidelines to preclude the administrative agency from exercising unbridled discretion in creating policy or applying the law.[19]

An agency begins the formal rulemaking process by filing a notice of the proposed rule.[20] The notice is published by the Department of State in the Florida Administrative Register[21] and must provide certain information, including the text of the proposed rule, a summary of the agency's statement of estimated regulatory costs (SERC), if one is prepared, and how a party may request a public hearing on the proposed rule. The SERC must include an economic analysis projecting a proposed rule's adverse effect on specified aspects of the state's economy or increase in regulatory costs.[22]

---

[12] See Florida Administrative Register, Vol. 41/39, published February 26, 2015, and Vol. 41/21, published February 2, 2015. The Florida Administrative Register is available on the Internet at www.flrules.org.
[13] Section 120.52(16); *Florida Department of Financial Services v. Capital Collateral Regional Counsel-Middle Region,* 969 So. 2d 527, 530 (Fla. 1st DCA 2007).
[14] *Southwest Florida Water Management District v. Save the Manatee Club, Inc.,* 773 So. 2d 594 (Fla. 1st DCA 2000).
[15] Section 120.52(17).
[16] Section 120.54(1)(a), F.S.
[17] Section 120.52(8) & s. 120.536(1), F.S.
[18] *Save the Manatee Club, Inc.,* supra at 599.
[19] *Sloban v. Florida Board of Pharmacy,* 982 So. 2d 26, 29-30 (Fla. 1st DCA 2008); *Board of Trustees of the Internal Improvement Trust Fund v. Day Cruise Association, Inc.,* 794 So. 2d 696, 704 (Fla. 1st DCA 2001).
[20] Section 120.54(3)(a)1., F.S.
[21] Section 120.55(1)(b)2., F.S.
[22] Section 120.541(2)(a), F.S.

The economic analysis mandated for each SERC must analyze several factors regarding a rule's potential impact over the 5 year period from when the rule goes into effect. First is the rule's likely adverse impact on economic growth, private-sector job creation or employment, or private-sector investment.[23] Next is the likely adverse impact on business competitiveness,[24] productivity, or innovation.[25] Finally, the analysis must discuss whether the rule is likely to increase regulatory costs, including any transactional costs.[26] If the analysis shows the projected aggregate impact of the proposed rule in any one of these areas will exceed $1 million in the first 5 years of implementation, the rule cannot go into effect until ratified by the Legislature pursuant to s. 120.541(3), F.S.

Present law distinguishes between a rule being "adopted" and becoming enforceable or "effective."[27] A rule must be filed for adoption before it may go into effect[28] and cannot be filed for adoption until completion of the rulemaking process.[29] A rule projected to have a specific economic impact exceeding $1 million in the aggregate over 5 years[30] must be ratified by the Legislature before going into effect.[31] Therefore, such a rule a rule must be filed for adoption before being submitted for legislative ratification and becomes effective when the ratification bill becomes law.

Effect of the PCS

The PCS amends s. 440.13(12), F.S., removing the obligation of the three-member panel to annually adopt MRAs. It permits the three-member panel to review and revise the MRAs as necessary. The PCS requires the DFS to adopt the three-member panel's approved MRAs by order. The order adopting the MRAs is subject to the notice, petition, and hearing requirements of ss. 120.569 and 120.57, F.S. This gives any substantially affected person the right to challenge the order and have their rights determined through the administrative law process. The resulting final order is subject to judicial review under s. 120.68, F.S. Persons that are adversely affected by the final order have the right to an appeal to the state's District Courts of Appeal.[32] The MRA adoption process will no longer be conducted by rule and will not be subject to legislative ratification.

B. SECTION DIRECTORY:

Section 1: Amends s. 440.13, F.S., providing that adoption of statewide schedules of maximum reimbursement allowances approved by the three-member panel shall be by order of the Department of Financial Services and subject to the administrative law proceedings of ss. 120.569 and 120.57, F.S., and judicial review under s. 120.68, F.S.

Section 2: Provides an effective date of July 1, 2015.

---

[23] Section 120.541(2)(a)1., F.S.

[24] This consideration includes the effect on the ability of those doing business in Florida to compete with those doing business in other states or domestic markets.

[25] Section 120.541(2)(a) 2., F.S.

[26] Section 120.541(2)(a) 3., F.S.

[27] Section 120.54(3)(e)6. Before a rule becomes enforceable, thus "effective," the agency first must complete the rulemaking process and file the rule for adoption with the Department of State.

[28] Id.

[29] Section 120.54(3)(e), F.S.

[30] Section 120.541(2)(a), F.S.

[31] Section 120.541(3), F.S.

[32] Section 120.68, F.S., usually results in appellate jurisdiction in the District Court of Appeal (DCA) where the agency is headquartered. Since the DFS is headquartered in Leon County, the 1st DCA will usually be the venue for review of the order. The 1st DCA is also the primary venue for workers' compensation cases in general and has a workers' compensation appellate law unit on staff.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The PCS has an indeterminate, but likely positive, impact on state government expenditures. The PCS changes the process for adopting revisions to the three-member panel approved MRAs. To the extent that it increases efficiency in adopting the revisions, it will have a positive impact.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None. Changing the process of adopting and making the three-member panel's actions effective is not expected to have an economic or fiscal impact. The PCS has the effect of changing the process, but it does not directly result in the adoption of any MRAs.

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:

The PCS removes the oversight of legislative ratification from statewide schedules of maximum reimbursement allowances approved by the three-member panel currently adopted by rule. They will be adopted by DFS order subject to an administrative hearing and judicial review.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to maximum reimbursement allowances
3 for workers' compensation medical services; amending
4 s. 440.13, F.S.; revising the process for establishing
5 schedules of maximum reimbursement allowances; making
6 adoption of schedules of maximum reimbursement
7 allowances subject to judicial review under s. 120.68,
8 F.S.; providing an effective date.
9
10 Be It Enacted by the Legislature of the State of Florida:
11
12 Section 1. Paragraph (a) of subsection (12) of section
13 440.13, Florida Statutes, is amended to read:
14 440.13 Medical services and supplies; penalty for
15 violations; limitations.—
16 (12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM
17 REIMBURSEMENT ALLOWANCES.—
18 (a) A three-member panel is created, consisting of the
19 Chief Financial Officer, or the Chief Financial Officer's
20 designee, and two members to be appointed by the Governor,
21 subject to confirmation by the Senate, one member who, on
22 account of present or previous vocation, employment, or
23 affiliation, shall be classified as a representative of
24 employers, the other member who, on account of previous
25 vocation, employment, or affiliation, shall be classified as a
26 representative of employees. The panel shall determine statewide

27 schedules of maximum reimbursement allowances for medically
28 necessary treatment, care, and attendance provided by
29 physicians, hospitals, ambulatory surgical centers, work-
30 hardening programs, pain programs, and durable medical
31 equipment. The maximum reimbursement allowances for inpatient
32 hospital care shall be based on a schedule of per diem rates, to
33 be approved by the three-member panel no later than March 1,
34 1994, to be used in conjunction with a precertification manual
35 as determined by the department, including maximum hours in
36 which an outpatient may remain in observation status, which
37 shall not exceed 23 hours. All compensable charges for hospital
38 outpatient care shall be reimbursed at 75 percent of usual and
39 customary charges, except as otherwise provided by this
40 subsection. Annually, the three-member panel shall ~~adopt~~ <u>review</u>
41 <u>and revise as necessary</u> schedules of maximum reimbursement
42 allowances for physicians, hospital inpatient care, hospital
43 outpatient care, ambulatory surgical centers, work-hardening
44 programs, and pain programs. An individual physician, hospital,
45 ambulatory surgical center, pain program, or work-hardening
46 program shall be reimbursed either the agreed-upon contract
47 price or the maximum reimbursement allowance in the appropriate
48 schedule. <u>Subject to the requirements of ss. 120.569 and 120.57,</u>
49 <u>the schedules of maximum reimbursement allowances as determined</u>
50 <u>by the three-member panel shall be adopted by order of the</u>
51 <u>department. Such order is subject to judicial review under s.</u>
52 <u>120.68.</u> The department, as requested, shall provide data to the

53 panel, including, but not limited to, utilization trends in the
54 workers' compensation health care delivery system. The
55 department shall provide the panel with an annual report
56 regarding the resolution of medical reimbursement disputes and
57 any actions pursuant to subsection (8). The department shall
58 provide administrative support and service to the panel to the
59 extent requested by the panel. For prescription medication
60 purchased under the requirements of this subsection, a
61 dispensing practitioner shall not possess such medication unless
62 payment has been made by the practitioner, the practitioner's
63 professional practice, or the practitioner's practice management
64 company or employer to the supplying manufacturer, wholesaler,
65 distributor, or drug repackager within 60 days of the dispensing
66 practitioner taking possession of that medication.
67 Section 2. This act shall take effect July 1, 2015.