SB 456 by **Braynon (CO-INTRODUCERS) Smith**; (Similar to H 0325) Labor Pools

SB 404 by **Simpson**; (Similar to H 0973) Improvements to Real Property Damaged by Sinkhole Activity

SB 836 by **Latvala**; (Similar to CS/H 0557) Florida Insurance Guaranty Association

851116	A	S	BI, Montford	Delete L.205:	03/09 01:40 PM
548084	A	S	BI, Montford	Delete L.232:	03/09 10:23 AM

SB 1126 by **Altman**; (Similar to H 0749) Continuing Care Communities

241974	A	S	BI, Richter	Delete L.66 - 272:	03/09 01:00 PM

SB 1094 by **Brandes**; (Similar to H 0895) Peril of Flood

591894	A	S	BI, Lee	Delete L.71 - 96:	03/09 01:26 PM
657366	A	S	BI, Lee	Delete L.128 - 150:	03/09 01:27 PM
611562	A	S	BI, Lee	Delete L.198:	03/09 01:27 PM
114946	A	S	BI, Lee	Delete L.216 - 223:	03/09 01:27 PM
748102	A	S	BI, Lee	Delete L.245 - 256:	03/09 01:27 PM

SB 916 by **Montford**; (Similar to CS/H 0639) Commercial Insurer Rate Filing Procedures

634480	A	S	BI, Montford	Delete L.23 - 71:	03/09 07:28 AM

SB 728 by **Benacquisto**; (Identical to H 1021) Health Insurance Coverage for Opioids

SB 842 by **Benacquisto**; (Similar to H 0715) Citizens Property Insurance Corporation Eligibility for Coverage

430690	A	S	BI, Benacquisto	Delete L.145 - 155:	03/09 01:34 PM

SB 1060 by **Simmons**; (Similar to H 1013) Maximum Reimbursement Allowances

594738	D	S	BI, Simmons	Delete everything after	03/09 12:57 PM

SB 1130 by **Simmons**; (Similar to CS/H 0507) Windstorm Premium Discounts

250328	A	S	BI, Simmons	btw L.45 - 46:	03/09 12:50 PM

SB 830 by **Simmons**; (Similar to H 0405) Regulation of Corporation Not for Profit Self-insurance Funds

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Benacquisto, Chair
Senator Richter, Vice Chair

MEETING DATE: Tuesday, March 10, 2015
TIME: 1:30 —3:30 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Benacquisto, Chair; Senator Richter, Vice Chair; Senators Clemens, Detert, Hukill, Lee, Margolis, Montford, Negron, Simmons, and Smith

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 456** Braynon (Similar H 325)	Labor Pools; Revising methods by which a labor pool is required to compensate day laborers; requiring a labor pool to provide certain notice before a day laborer's first pay period; specifying requirements for a labor pool that selects to compensate a day laborer by payroll debit card; authorizing a labor pool to deliver a wage statement electronically upon request by the day laborer, etc. CM 02/16/2015 Favorable BI 03/10/2015 RC	
2	**SB 404** Simpson (Similar H 973)	Improvements to Real Property Damaged by Sinkhole Activity; Declaring that there is a compelling state interest in enabling property owners to voluntarily finance certain improvements to property damaged by sinkhole activity with local government assistance; expanding the definition of the term "qualifying improvement" to include stabilization or other repairs to property damaged by sinkhole activity; expanding the definition of "blighted area" to include a substantial number or percentage of properties damaged by sinkhole activity which are not adequately repaired or stabilized, etc. CA 02/17/2015 Favorable BI 03/10/2015 FT RC	
3	**SB 836** Latvala (Similar CS/H 557)	Florida Insurance Guaranty Association; Revising provisions relating to the levy of assessments on insurers by the Florida Insurance Guaranty Association; requiring charges or recoupments to be displayed separately on premium statements to policyholders and prohibiting their inclusion in rates, etc. BI 03/10/2015 AGG AP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1126** Altman (Similar H 749)	Continuing Care Communities; Revising authority of the Office of Insurance Regulation to waive requirements for accredited facilities; providing that continuing care and continuing care at-home contracts are preferred claims in the event of bankruptcy proceedings against a provider; requiring an agent of a provider to provide a copy of an examination report and corrective action plan under certain conditions; requiring a residents' council to provide a forum for certain purposes; revising provisions relating to quarterly meetings between residents and the governing body of the provider, etc. BI 03/10/2015 AGG FP	
5	**SB 1094** Brandes (Similar H 895)	Peril of Flood; Specifying components that must be contained in the coastal management element required for a local government comprehensive plan; requiring a licensed surveyor and mapper to complete an elevation certificate in accordance with a checklist developed by the Division of Emergency Management and to submit a copy of the elevation certificate to a specified property appraiser within a certain time after its completion; revising the required coverage for customized flood insurance, etc. BI 03/10/2015 CA RC	
6	**SB 916** Montford (Similar CS/H 639)	Commercial Insurer Rate Filing Procedures; Amending provisions limiting to residential property insurers the requirement that property insurers certify certain information presented in rate filings as truthful, complete, and in compliance with specified actuarial techniques; revising the types of commercial insurers that are exempt from making certain required annual base rate filings with the Office of Insurance Regulation, etc. BI 03/10/2015 CM RC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 728** Benacquisto (Identical H 1021)	Health Insurance Coverage for Opioids; Providing that a health insurance policy that covers opioid analgesic drug products may impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the insurer imposes the same requirement for each opioid analgesic drug product without an abuse-deterrence labeling claim; prohibiting such health insurance policy from requiring use of an opioid analgesic drug product without an abuse-deterrence labeling claim before providing coverage for an abuse-deterrent opioid analgesic drug product, etc. BI 03/10/2015 HP AP	
8	**SB 842** Benacquisto (Similar H 715)	Citizens Property Insurance Corporation Eligibility for Coverage; Removing the prohibition against permits for substantial improvements from being eligible for coverage; authorizing coverage for major structures built before a certain date and subsequently rebuilt, repaired, restored, or remodeled to a specified percentage less than the major structure's original square footage, etc. BI 03/10/2015 CA FP	
9	**SB 1060** Simmons (Similar H 1013)	Maximum Reimbursement Allowances; Providing that a specified restriction does not apply to the adoption of maximum reimbursement allowances approved by the three-member panel, etc. BI 03/10/2015 FP	
10	**SB 1130** Simmons (Similar CS/H 507)	Windstorm Premium Discounts; Providing that an insurer issuing a policy to a new policyholder may accept as valid only specified uniform mitigation verification inspection forms, etc. BI 03/10/2015 CA FP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
11	**SB 830** Simmons (Similar H 405)	Regulation of Corporation Not for Profit Self-insurance Funds; Revising the requirements for a participating member of a corporation not for profit self-insurance fund, etc. BI 03/04/2015 Temporarily Postponed BI 03/10/2015 CM FP	

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 456
INTRODUCER:	Senators Braynon and Smith
SUBJECT:	Labor Pools
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Siples	McKay	CM	**Favorable**
2.	Knudson	Knudson	BI	**Pre-meeting**
3.			RC	

I. Summary:

SB 456 allows labor pools to offer additional methods to compensate day laborers for services performed. These new methods include an electronic fund transfer to the financial institution designated by the day laborer and a payroll debit card, which does not charge a fee for withdrawal of its contents. The labor pool must notify the day laborer of the payment method it intends to use and provide the day laborer the option to be paid by another authorized method. The bill authorizes the labor pool to provide a wage statement electronically upon written request of the day laborer.

II. Present Situation:

The Labor Pool Act

Part II of ch. 448, F.S., also known as the Labor Pool Act,[1] was enacted in 1995 to protect the health, safety, and well-being of day laborers throughout the state. The act also outlines uniform standards of conduct and practice for labor pools. A labor pool is defined as a business entity that operates a labor hall[2] by one or more of the following methods:

- Contracting with third-party users to supply day laborers to them on a temporary basis;
- Hiring, employing, recruiting, or contracting with workers to fulfill these contracts for temporary labor; or
- Fulfilling any contracts for day labor in accordance with the act, even if the entity also conducts other business.[3]

[1] Chapter 95-332, L.O.F.

[2] Section 448.22(3), F.S., defines a "labor hall" as a central location maintained by a labor pool where day laborers assemble and are dispatched to work for a third-party user.

[3] Section 448.22(1), F.S. The act also specifically excludes certain businesses from its provisions: businesses registered as farm labor contractors; employee leasing companies; temporary help services that solely provide white collar employees,

The act limits the methods by which a day laborer may be paid to cash or commonly accepted negotiable instruments[4] that are payable in cash, on demand at a financial institution, and without discount.[5] The act prohibits a labor pool from charging a day laborer for directly or indirectly cashing the worker's check.[6]

Payment for Labor

Chapter 532, F.S., governs the issuance of payment for labor in this state. Under the law, payment for labor may be made by order, check, draft, note, memorandum, payroll debit card, or other acknowledgment of indebtedness issued in payment of wages and payable in cash, on demand, without discount, at an established place of business.[7] It further requires the name and address of a business where a payroll debit card is negotiable on demand without discount to appear on the payroll debit card.

Payroll Debit Cards

More companies are using payroll debit cards to compensate their employees for their labor. The number of companies using this method to pay employees is expected to reach 10.8 million within the next 5 years.[8] However, some consumer advocates warn that employees paid by these debit cards may be subjected to fees for transactions, such as withdrawals, balance inquiries, and point of sale purchases.[9] Some of the payroll debit card issuers may also charge its cardholders overdraft and inactivity fees.

However, payroll debit cards may offer an individual who has limited or no access to a financial institution a safe and convenient way to receive her or his wages.[10] The Consumers Union and the National Consumer Law Center has issued a Model State Payroll Card Law, which they feel offer a mutually beneficial payroll program for both employers and employees.[11] The model law includes such provisions as:

- Requirement of a voluntary written consent to receive payment by payroll card;

secretarial employees, clerical employees, or skilled laborers; labor union hiring halls; or labor bureau or employment offices operated by a business entity for the sole purpose of employing an individual for its own use. *See* s. 448.23, F.S.

[4] Section 673.1041(1), F.S., defines negotiable instrument as "an unconditional promise or order to pay a fixed amount of money, with or without interest or other charges described in the promise or order, if it: (a)is payable to the bearer or to order at the time it is issued or first comes into possession of a holder; (b) is payable on demand or at a definite time; and (c) does not state any other undertaking or instruction by the person promising or ordering payment to do any act in addition to the payment of money…"

[5] Section 448.24(2)(a), F.S.

[6] Section 448.24(1)(c), F.S.

[7] Section 532.01, F.S.

[8] Sandra Pedicini, *More Companies Opt to Give Workers Payroll Debit Cards*, ORLANDO SENTINEL, Oct. 6, 2013, *available at* http://articles.orlandosentinel.com/2013-10-06/business/os-cfb-cover-payroll-cards-20131006_1_debit-cards-payroll-cards-such-cards (last visited Feb. 5, 2015).

[9] *Id. See also* Jessica Silver-Greenberg and Stephanie Clifford, *Paid via Card, Workers Feel Sting of Fees*, NEW YORK TIMES, June 30, 2013, *available at* http://www.nytimes.com/2013/07/01/business/as-pay-cards-replace-paychecks-bank-fees-hurt-workers.html?pagewanted=all&_r=1& (last visited Feb. 5, 2015).

[10] Press Release, American Payroll Association and National Consumer Law Center, *American Payroll Association, National Consumer Law Center Agree Payroll Cards Make Sense for Unbanked If Proper Guidelines Followed*, July 31, 2013, *available at* https://www.nclc.org/images/pdf/pr-reports/pr_effective-payroll-card2013.pdf (last visited Feb. 5, 2015).

[11] *Id. See also* Consumers Union and National Consumer Law Center, *Model State Payroll Card Law* (Feb. 2011), *available at* http://consumersunion.org/wp-content/uploads/2013/02/Payroll-Model-Law.pdf (last visited Feb. 5, 2015).

- The availability of wages without a fee at least once each pay period;
- A prohibition of certain other fees, such as fees for point of sale transactions, declined transactions, balance inquiry, and account activity;
- A provision of a periodic statement and transaction history;
- Requirement to disclose available payment options to the employee;
- A provision that allows an employee to change the wage payment method;
- A prohibition on linking the payroll card to any form of credit account or fee-based overdraft program; and
- A requirement that payroll card funds be placed in an FDIC or NCUA insured account.

Federal Payroll Card Regulations

The Electronic Funds Transfer Act (EFTA), Regulation E, governs the use of payroll card accounts.[12] The regulation outlines the requirements for financial institutions offering payroll credit accounts.[13] The regulation provides instructions on providing account information to the consumer and general account information and disclosures. Additionally, financial institutions issuing payroll card accounts are instructed on limitations on liability for unauthorized account transactions that are timely reported. The regulation prohibits a financial institution or other person from requiring an individual to receive wages by electronic funds transfer with a particular institution, including payroll cards, as a condition of employment.[14]

III. Effect of Proposed Changes:

Section 1 amends s. 448.24, F.S., to permit labor pools to pay a day laborer by payroll debit card or electronic funds transfer, in addition to the current options of payment by cash or a negotiable instrument that is payable in cash.

The bill provides that before the first pay period, a day laborer must be advised of the method of payment the labor pool uses, and the payment options available. A day laborer must be given the opportunity to opt out of receiving his or her wages by payroll debit card or electronic fund transfer.

If a labor pool opts to pay wages by payroll debit card, the labor pool must:
- Offer to provide wages by electronic fund transfer; and
- Prior to selecting to pay a day laborer by payroll debit card, provide a list of businesses in close proximity of the labor pool that will allow the day laborer to withdraw the contents of the payroll debit card without a fee.

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[12] 12 C.F.R. s. 1005.2(b)(2). Payroll card account is defined as "an account that is directly or indirectly established through an employer and to which electronic fund transfers of the consumer's wages, salary, or other employee compensation (such as commissions), are made on a recurring basis, whether the account is operated or managed by the employer, a third-party payroll processor, a depository institution or any other person."
[13] 12 C.F.R. s. 1005.18. *See also*, Consumer Financial Protection Bureau, *Payroll Credit Accounts (Regulation E)*, CFPB Bulletin 2013-10 (Sept. 13, 2013), *available at* http://files.consumerfinance.gov/f/201309_cfpb_payroll-card-bulletin.pdf (last visited Feb. 5, 2015).
[14] 12 C.F.R. s. 1005.10(e)(2).

Current law requires a labor pool to provide the day laborer with a written, itemized statement of wages including all deductions made from his or her wages. The bill authorizes a labor pool to provide this itemized statement in an electronic format, upon written request of the day laborer.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

An employee being paid by this method may be able to avoid or reduce check-cashing fees or other fees incurred for accessing wages, if the employee does not have access or has limited access to traditional banking services.

An employer may save costs associated with the issuance of a paper check.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not define "close proximity." Although the term is used in several statutes to delineate distance,[15] only two provisions provide a definition.[16] Section 627.736(7)(a), F.S., uses the term "area of the closest proximity." This term was reviewed by the Fifth District Court of Appeal, which found this term to mean the same or closest metropolitan area.[17]

The bill requires that a day laborer be provided a list of locations where the contents of the debit card may be withdrawn without a fee. However, it is unclear whether the entire contents of the debit card must be withdrawn in a single occurrence to avoid a fee, or if multiple partial withdrawals are also allowed without a fee.

VIII. Statutes Affected:

This bill substantially amends section 448.24 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[15] *For example*, ss. 39.6012, 119.071, 163.3175, 310.101, 310.141, 331.310, 341.031, 380.0552, 403.7211, 561.01, and 856.022, F.S.
[16] Sections 119.071(3)(c)5.b. and 561.01(18), F.S., include in the definition of "entertainment or resort complex" lodging, dining, and recreational facilities adjacent to, contiguous to, or in close proximity to a theme park. Close proximity is defined to include an area within a 5-mile radius of the theme park complex.
[17] *Progressive American Insurance Co. v. Belcher*, 496 So.2d 841, 843 (Fla. 5th DCA 1986).

By Senator Braynon

36-00502B-15 2015456__

A bill to be entitled

An act relating to labor pools; amending s. 448.24, F.S.; revising methods by which a labor pool is required to compensate day laborers; requiring a labor pool to provide certain notice before a day laborer's first pay period; specifying requirements for a labor pool that selects to compensate a day laborer by payroll debit card; authorizing a labor pool to deliver a wage statement electronically upon request by the day laborer; providing an effective date.

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

Section 1. Subsection (2) of section 448.24, Florida Statutes, is amended to read:

448.24 Duties and rights.—

(2) A labor pool shall:

(a) Select one of the following methods of payment to compensate a day laborer ~~laborers~~ for work performed: ~~in the form of~~

1. Cash.~~, or~~

2. Commonly accepted negotiable instruments that are payable in cash, on demand at a financial institution, and without discount.

3. Payroll debit card.

4. Electronic fund transfer, which must be made to a financial institution designated by the day laborer.

(b) Before a day laborer's first pay period, provide notice to the day laborer of the method of payment that the labor pool

36-00502B-15 2015456__

intends to use for payroll and the day laborer's options to elect a different method of payment, and authorize the day laborer to elect not to be paid by payroll debit card or electronic fund transfer.

(c) If selecting to compensate a day laborer by payroll debit card:

1. Offer the day laborer the option to elect payment by electronic fund transfer; and

2. Before selecting payroll debit card, provide the day laborer with a list, including the address, of a business that is in close proximity to the labor pool and that does not charge a fee to withdraw the contents of the payroll debit card.

(d) ~~(b)~~ Compensate day laborers at or above the minimum wage, in conformance with ~~the provision of~~ s. 448.01. ~~In no event shall any~~ Deductions, other than those authorized ~~permitted~~ by federal or state law, may not bring the worker's pay below minimum wage for the hours worked.

(e) ~~(c)~~ Comply with all requirements of chapter 440.

(f) ~~(d)~~ Insure any motor vehicle owned or operated by the labor hall and used for the transportation of workers pursuant to Florida Statutes.

(g) ~~(c)~~ At the time of each payment of wages, furnish each worker a written itemized statement showing in detail each deduction made from such wages. A labor pool may deliver this statement electronically upon written request of the day laborer.

(h) ~~(f)~~ Provide each worker with an annual earnings summary within a reasonable period of time after the end of the preceding calendar year, but no later than February 1.

Section 2. This act shall take effect July 1, 2015.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 404
INTRODUCER:	Senator Simpson
SUBJECT:	Improvements to Real Property Damaged by Sinkhole Activity
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	White	Yeatman	CA	**Favorable**
2.	Billmeier	Knudson	BI	**Pre-meeting**
3.			FT	
4.			RC	

I. Summary:

SB 404 authorizes local governments to enter into financing agreements with property owners to finance qualified improvements to property damaged by sinkhole activity. Additionally, the bill expands the definition of "blighted area," enabling community redevelopment areas to enter into voluntary contracts to redevelop properties damaged by sinkhole activity.

II. Present Situation:

The Property Assessed Clean Energy Model

The Property Assessed Clean Energy (PACE) Program enables local governments to encourage property owners to reduce energy consumption and increase energy efficiency. The PACE model allows individual residential, commercial, or industrial property owners to contract directly with qualified contractors for energy efficiency and renewable energy projects. The local government provides the upfront funding for the project through proceeds of a revenue bond issuance, which is repaid through an assessment on participating property owners' tax bills.[1]

Voluntary Energy and Wind Resistant Real Property Improvements

The 2010 Legislature passed an expanded form of the PACE model.[2] Section 163.08, F.S., provides supplemental authority to local governments regarding qualified improvements to real property. The law provides that if a local government passes an ordinance or adopts a resolution to create a program to provide up-front financing for energy conservation and efficiency, renewable energy, or wind resistance improvements, a property owner within the jurisdiction of that local government may apply to the local government for funding to finance a qualifying

[1] For more information, see http://www.pacenow.org, and http://floridapace.gov/ (last visited Feb. 10, 2015).
[2] CS/HB 7179, chapter 2010-139, L.O.F.

improvement and voluntarily enter into a financing agreement with the local government. "Qualifying improvements" include energy conservation and efficiency improvements; renewable energy improvements; and wind resistance improvements.

At least 30 days before entering into the financing agreement, the property owner must provide notice to the mortgage holder or loan servicer of the intent to enter into the agreement, the maximum amount to be financed, and the maximum annual assessment that will be required to repay the amount.[3] The law provides that an acceleration clause for "payment of the mortgage, note, or lien or other unilateral modification solely as a result of entering into a financing agreement as provided for in this section is not enforceable."[4] However, the mortgage holder or loan servicer may increase the required monthly escrow by an amount necessary to annually pay the qualifying improvement assessment.

The law authorizes a local government to: partner with one or more local governments for the purpose of providing and financing qualifying improvements; levy a non-ad valorem assessment to fund a qualifying improvement; incur debt to provide financing for qualifying improvements; and collect costs incurred from financing qualifying improvements through a non-ad valorem assessment. These non-ad valorem assessments would be senior to existing mortgage debt, so if the homeowner defaults or goes into foreclosure, the delinquent payments would be recovered before the mortgage. In 2012, the Legislature clarified that a partnership of local governments may enter into a financing agreement and that the separate legal entity may impose the voluntary special assessments for purposes of the program.[5]

Specific qualifying improvements are locally determined in the twelve Florida counties where programs exist.[6] To participate in a program, property owners must have paid property taxes and not been delinquent for the previous 3 years.[7] The total assessment cannot be for an amount greater than 20 percent of the just value of the property as determined by the county property appraiser, unless consent is obtained from the mortgage holders.[8] In 2010, the Federal Housing Finance Agency (FHFA), directed mortgage underwriters Fannie Mae and Freddie Mac against purchasing mortgages of homes with a PACE lien due to its senior status above a mortgage.[9] Although residential PACE activity subsided following this directive, some residential PACE

[3] Section 163.08(13), F.S.
[4] *Id*., Section 163.08(15), F.S.
[5] Chapter 2012-117, L.O.F.
[6] Database of State Incentives for Renewables & Efficiency, *Florida PACE Financing*, available at http://dsireusa.org/incentives/incentive.cfm?Incentive_Code=FL93F&re=1&ee=1 (last visited Feb. 10, 2015).
[7] Section 163.08(9), F.S.
[8] Section 163.08(12)(a), F.S.
[9] Federal Housing Finance Agency, *FHFA Statement on Certain Energy Retrofit Loan Programs* (July, 6, 2010), available at http://www.fhfa.gov/Media/PublicAffairs/Pages/FHFA-Statement-on-Certain-Energy-Retrofit-Loan-Programs.aspx (last visited Feb. 10, 2015). *See also* Federal Housing Financial Agency, *Statement of the Federal Housing Finance Agency on Certain Super Priority Liens* (December 22, 2014)("FHFA wants to make clear to homeowners, lenders, other financial institutions, state officials, and the public that Fannie Mae and Freddie Mac's policies prohibit the purchase of a mortgage where the property has a first-lien PACE loan attached to it") available at http://www.fhfa.gov/Media/PublicAffairs/Pages/Statement-of-the-Federal-Housing-Finance-Agency-on-Certain-Super-Priority-Liens.aspx (last visited March 6, 2015).

programs are now operating with loan loss reserve funds, appropriate disclosures, or other protections meant to address FHFA's concerns.[10]

Community Redevelopment Act

The Community Redevelopment Act of 1969,[11] authorizes a county or municipality to create community redevelopment areas (CRAs) as a means of redeveloping slums and blighted areas. In accordance with a community redevelopment plan,[12] CRAs can:

- enter into contracts,
- disseminate information,
- acquire property within a slum or blighted area by voluntary methods,
- demolish and remove buildings and improvements,
- construct improvements, and
- dispose of property at fair value.[13]

CRAs are not permitted to levy or collect taxes; however, the local governing body is permitted to establish a community redevelopment trust fund that is funded through tax increment financing (TIF).[14] Taxing authorities must annually appropriate an amount representing the calculated increment revenue to the redevelopment trust fund. This revenue is used to back bonds issued to finance redevelopment projects. School district revenues are not subject to the tax increment mechanism.

Counties and municipalities are prohibited from exercising the community redevelopment authority provided by the Community Redevelopment Act until they adopt an ordinance that declares an area to be a slum or a blighted area.[15]

Section 163.340(8), F.S., defines "blighted area" as follows:

> An area in which there are a substantial number of deteriorated, or deteriorating structures, in which conditions, as indicated by government-maintained statistics or other studies, are leading to economic distress or endanger life or property, and in which two or more of the following factors are present:
> (a) Predominance of defective or inadequate street layout, parking facilities, roadways, bridges, or public transportation facilities;
> (b) Aggregate assessed values of real property in the area for ad valorem tax purposes have failed to show any appreciable increase over the 5 years prior to the finding of such conditions;
> (c) Faulty lot layout in relation to size, adequacy, accessibility, or usefulness;
> (d) Unsanitary or unsafe conditions;
> (e) Deterioration of site or other improvements;

[10] Commercial PACE programs were not directly affected by FHFA's actions. Database of State Incentives for Renewables & Efficiency, *supra* note 6.
[11] Chapter 163, F.S., part III.
[12] Section 163.360, F.S.
[13] Section 163.370, F.S.
[14] Through tax increment financing, a baseline tax amount is chosen, and then in future years, any taxes generated above that baseline amount are transferred into the trust fund. Section 163.387, F.S.
[15] Sections 163.355(1) and 163.360(1), F.S.

(f) Inadequate and outdated building density patterns;
(g) Falling lease rates per square foot of office, commercial, or industrial space compared to the remainder of the county or municipality;
(h) Tax or special assessment delinquency exceeding the fair value of the land;
(i) Residential and commercial vacancy rates higher in the area than in the remainder of the county or municipality;
(j) Incidence of crime in the area higher than in the remainder of the county or municipality;
(k) Fire and emergency medical service calls to the area proportionately higher than in the remainder of the county or municipality;
(l) A greater number of violations of the Florida Building Code in the area than the number of violations recorded in the remainder of the county or municipality;
(m) Diversity of ownership or defective or unusual conditions of title which prevent the free alienability of land within the deteriorated or hazardous area; or
(n) Governmentally owned property with adverse environmental conditions caused by a public or private entity.

However, the term "blighted area" also means any area in which at least one of the factors identified in paragraphs (a) through (n) are present and all taxing authorities subject to s. 163.387(2)(a), F.S., agree, either by inter-local agreement or agreements with the agency or by resolution, that the area is blighted.

Subsidence and Sinkholes

Ground subsidence refers to a downward motion in the surface of the Earth, and may be caused by the dissolution of carbonate rocks, mining, earthquakes, extraction of natural gas, and changes to groundwater levels. A sinkhole has been defined as a "a landform created by subsidence of soil, sediment, or rock as underlying strata are dissolved by groundwater. A sinkhole forms by collapse into subterranean voids created by dissolution of limestone or dolostone or by subsidence as these strata are dissolved."[16] Sinkholes are a common feature in Florida's landscape, due to erosional processes associated with the chemical weathering and dissolution of carbonate rocks.[17] Over geologic periods of time, persistent erosion created extensive underground voids and drainage systems throughout Florida.[18] A sinkhole forms when sediments overlying such a void collapse. Because "groundwater that feeds springs is recharged … through direct conduits such as sinkholes," the Florida Legislature has expressed a desire to promote good stewardship, effective planning strategies, and best management practices with respect to sinkholes and the springs they recharge, which may be "threatened by actual and potential flow reductions and declining water quality."[19]

[16] Section 627.706(2)(h), F.S.
[17] Such as limestone and dolomite. See, Florida Dep't of Environmental Protection, *Sinkholes, available at* http://www.dep.state.fl.us/geology/geologictopics/sinkhole.htm (last visited Feb. 6, 2015).
[18] *Id*.
[19] Section 369.315, F.S.

The two most commonly recommended stabilization techniques for sinkholes are grouting and underpinning.[20] Under the grouting procedure, a grout mixture (either cement-based or a chemical resin that expands into foam) is injected into the ground to stabilize the subsurface soils to minimize further subsidence damage by increasing the density of the soils beneath the building as well as sealing the top of the limestone surface to minimize future raveling.[21] Underpinning consists of steel piers drilled or pushed into the ground to stabilize the building's foundation.[22] One end of the steel pipe connects to the foundation of the structure with the other end resting on solid limestone. Underpinning repairs, when performed, are usually combined with grouting.

III. Effect of Proposed Changes:

Section 1 amends s. 163.08, F.S., to allow supplemental authority for financing sinkhole-related improvements to real property. The bill establishes a finding of a compelling state interest in providing local government assistance that enables property owners to finance qualified improvements to property damaged by sinkhole activity. The bill expands the definition of "qualifying improvement" to include stabilization or other repairs to property damaged by sinkhole activity. The bill provides that a sinkhole-related qualifying improvement is deemed affixed to a building or facility; and provides that a disclosure statement to that effect be given to a prospective purchaser of the property.

Section 2 amends s 163.340, F.S., to add certain sinkhole activity to the list of factors that define a "blighted area." Specifically, the definition is expanded to account for land that has a "substantial number or percentage of properties" that have been damaged by sinkhole activity and have not been adequately repaired or stabilized. Thus, the bill would enable a CRA focused on redeveloping land with properties damaged by sinkholes to establish a community redevelopment trust fund that is funded through tax increment financing.

Section 3 amends s. 163.524, F.S., to conform a cross-reference.

Section 4 provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[20] Citizens Property Insurance Corporation, Sinkhole Repairs: Underpinning and Grouting, (Oct. 30, 2012). https://www.citizensfla.com/shared/sinkhole/documents/GroutVersusUnderpinning.pdf (Last visited on March 7, 2015).
[21] See *id.*
[22] See *id*.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Section 163.08, F.S., amended by section 1 of this bill, is the subject of litigation in the Florida Supreme Court. In *Florida Bankers Association v. State*, Case No. SC14-1603, the Court is considering whether the statute impairs contractual obligations in violation of art. 1, s. 10, Fla. Const. In *Reynolds v. State*, Case No. SC14-1618, the Court is considering whether a financing agreement created pursuant to s. 163.08, F.S., impairs contractual obligations. The Court has scheduled oral argument in both cases for May 7, 2015.

Section 163.08(8), F.S., provides that an assessment levied to fund a qualifying improvement is senior to existing mortgage debt, so if the homeowner defaults or goes into foreclosure, the delinquent payments would be recovered before the mortgage. An issue in the pending court cases is whether the provision making the assessment senior to existing mortgages impairs the mortgage contracts in violation of art. 1, s. 10, Fla. Const.

Section 1 of this bill contains a finding of a compelling government interest in providing local government assistance to enable property owners to effect improvements on property damaged by sinkhole activity. In *Pomponio v. Claridge of Pompano Condo. Inc.*, 378 So.2d 774, 780 (Fla. 1979), the court explained that whether a statute impermissibly impairs contractual obligations is a "balancing process to determine whether the nature and extent of the impairment is constitutionally tolerable in light of the importance of the state's objective, or whether it unreasonably intrudes into the parties' bargain to a degree greater than is necessary to achieve that objective."

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Owners of property damaged by sinkhole activity will be able to enter into financing agreements with a local government that passes an ordinance or adopts a resolution to participate in the program established in s. 163.08, F.S.

Community redevelopment agencies will be able to develop a community redevelopment plan utilizing the expanded definition of "blighted area" to include land that has been "damaged by sinkhole activity which have not been adequately repaired or stabilized." As a result, these areas may receive TIF revenues under the Community Redevelopment Act, and property values in the area may increase as a result of any improvements using TIF. Redevelopment of these areas can contribute to increased economic interest in a region and an overall improved economic condition.

Counties and municipalities are required by s. 163.345, F.S., to prioritize private enterprise in the rehabilitation and redevelopment of blighted areas. The increase in ad valorem taxation could be used to finance private development projects within this new category of "blighted area." Overall property values in the surrounding area may also increase as a result, affecting current homeowners' resale values and ad valorem taxation.

C. Government Sector Impact:

Local governments will be authorized to establish a PACE program that finances qualifying improvements for property damaged by sinkhole activity. A local government that creates such a program will be able to provide upfront funding for stabilization or other repairs to property damaged by sinkhole activity through proceeds of a revenue bond issuance, which is repaid through an assessment on participating property owners' tax bills.

A municipality or county would be able to develop a community redevelopment plan utilizing the expanded definition of "blighted area" to include land that has a "substantial number or percentage of properties damaged by sinkhole activity which have not been adequately repaired or stabilized." This could result in a portion of the ad valorem taxes from those lands being used for TIF. County and municipal governments would then receive the benefit of the ad valorem tax revenue on the increase in property value within the CRA, but could see an increase in other aspects of the local economy.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 163.08, 163.340, and 163.524.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Simpson

18-00303-15 2015404__

A bill to be entitled

An act relating to improvements to real property damaged by sinkhole activity; amending s. 163.08, F.S.; declaring that there is a compelling state interest in enabling property owners to voluntarily finance certain improvements to property damaged by sinkhole activity with local government assistance; expanding the definition of the term "qualifying improvement" to include stabilization or other repairs to property damaged by sinkhole activity; providing that stabilization or other repairs to property damaged by sinkhole activity are qualifying improvements considered affixed to a building or facility; revising the form of a specified written disclosure statement to include an assessment for a qualifying improvement relating to stabilization or repair of property damaged by sinkhole activity; amending s. 163.340, F.S.; expanding the definition of "blighted area" to include a substantial number or percentage of properties damaged by sinkhole activity which are not adequately repaired or stabilized; conforming a cross-reference; amending s. 163.524, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Present paragraph (c) of subsection (1) of section 163.08, Florida Statutes, is redesignated as paragraph

18-00303-15 2015404__

(d), a new paragraph (c) is added to that subsection, and paragraph (b) of subsection (2) and subsections (10) and (14) of that section are amended, to read:

163.08 Supplemental authority for improvements to real property.—

(1)

(c) The Legislature finds that properties damaged by sinkhole activity which are not adequately repaired may negatively affect the market valuation of surrounding properties, resulting in the loss of property tax revenues to local communities. The Legislature finds that there is a compelling state interest in providing local government assistance to enable property owners to voluntarily finance qualified improvements to property damaged by sinkhole activity.

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

(b) "Qualifying improvement" includes any:

1. Energy conservation and efficiency improvement, which is a measure to reduce consumption through conservation or a more efficient use of electricity, natural gas, propane, or other forms of energy on the property, including, but not limited to, air sealing; installation of insulation; installation of energy-efficient heating, cooling, or ventilation systems; building modifications to increase the use of daylight; replacement of windows; installation of energy controls or energy recovery systems; installation of electric vehicle charging equipment; and installation of efficient lighting equipment.

2. Renewable energy improvement, which is the installation of any system in which the electrical, mechanical, or thermal energy is produced from a method that uses one or more of the

following fuels or energy sources: hydrogen, solar energy, geothermal energy, bioenergy, and wind energy.

3. Wind resistance improvement, which includes, but is not limited to:

a. Improving the strength of the roof deck attachment;

b. Creating a secondary water barrier to prevent water intrusion;

c. Installing wind-resistant shingles;

d. Installing gable-end bracing;

e. Reinforcing roof-to-wall connections;

f. Installing storm shutters; or

g. Installing opening protections.

4. Stabilization or other repairs to property damaged by sinkhole activity.

(10) A qualifying improvement shall be affixed to a building or facility that is part of the property and shall constitute an improvement to the building or facility or a fixture attached to the building or facility. For the purposes of stabilization or other repairs to property damaged by sinkhole activity, a qualifying improvement is deemed affixed to a building or facility. An agreement between a local government and a qualifying property owner may not cover wind-resistance improvements in buildings or facilities under new construction or construction for which a certificate of occupancy or similar evidence of substantial completion of new construction or improvement has not been issued.

(14) At or before the time a purchaser executes a contract for the sale and purchase of any property for which a non-ad valorem assessment has been levied under this section and has an

unpaid balance due, the seller shall give the prospective purchaser a written disclosure statement in the following form, which shall be set forth in the contract or in a separate writing:

QUALIFYING IMPROVEMENTS FOR ENERGY EFFICIENCY, RENEWABLE ENERGY, ~~OR~~ WIND RESISTANCE, OR SINKHOLE STABILIZATION OR REPAIR.—The property being purchased is located within the jurisdiction of a local government that has placed an assessment on the property pursuant to s. 163.08, Florida Statutes. The assessment is for a qualifying improvement to the property relating to energy efficiency, renewable energy, ~~or~~ wind resistance, or stabilization or repair of property damaged by sinkhole activity, and is not based on the value of property. You are encouraged to contact the county property appraiser's office to learn more about this and other assessments that may be provided by law.

Section 2. Subsection (8) of section 163.340, Florida Statutes, is amended to read:

163.340 Definitions.—The following terms, wherever used or referred to in this part, have the following meanings:

(8) "Blighted area" means an area in which there are a substantial number of deteriorated~~,~~ or deteriorating structures;~~,~~ in which conditions, as indicated by government-maintained statistics or other studies, endanger life or property or are leading to economic distress; ~~or endanger life or property,~~ and in which two or more of the following factors

are present:

(a) Predominance of defective or inadequate street layout, parking facilities, roadways, bridges, or public transportation facilities.~~,~~

(b) Aggregate assessed values of real property in the area for ad valorem tax purposes have failed to show any appreciable increase over the 5 years prior to the finding of such conditions.~~,~~

(c) Faulty lot layout in relation to size, adequacy, accessibility, or usefulness.~~,~~

(d) Unsanitary or unsafe conditions.~~,~~

(e) Deterioration of site or other improvements.~~,~~

(f) Inadequate and outdated building density patterns.~~,~~

(g) Falling lease rates per square foot of office, commercial, or industrial space compared to the remainder of the county or municipality.~~,~~

(h) Tax or special assessment delinquency exceeding the fair value of the land.~~,~~

(i) Residential and commercial vacancy rates higher in the area than in the remainder of the county or municipality.~~,~~

(j) Incidence of crime in the area higher than in the remainder of the county or municipality.~~,~~

(k) Fire and emergency medical service calls to the area proportionately higher than in the remainder of the county or municipality.~~,~~

(l) A greater number of violations of the Florida Building Code in the area than the number of violations recorded in the remainder of the county or municipality.~~,~~

(m) Diversity of ownership or defective or unusual

conditions of title which prevent the free alienability of land within the deteriorated or hazardous area.~~; or~~

(n) Governmentally owned property with adverse environmental conditions caused by a public or private entity.

(o) A substantial number or percentage of properties damaged by sinkhole activity which have not been adequately repaired or stabilized.

However, the term "blighted area" also means any area in which at least one of the factors identified in paragraphs (a) through (o) is ~~(n) are~~ present and all taxing authorities subject to s. 163.387(2)(a) agree, either by interlocal agreement ~~or agreements~~ with the agency or by resolution, that the area is blighted. Such agreement or resolution must be limited to a determination ~~shall only determine~~ that the area is blighted. For purposes of qualifying for the tax credits authorized in chapter 220, "blighted area" means an area as defined in this subsection.

Section 3. Subsection (3) of section 163.524, Florida Statutes, is amended to read:

163.524 Neighborhood Preservation and Enhancement Program; participation; creation of Neighborhood Preservation and Enhancement Districts; creation of Neighborhood Councils and Neighborhood Enhancement Plans.—

(3) After the boundaries and size of the Neighborhood Preservation and Enhancement District have been defined, the local government shall pass an ordinance authorizing the creation of the Neighborhood Preservation and Enhancement District. The ordinance shall contain a finding that the

boundaries of the Neighborhood Preservation and Enhancement District comply with ~~meet the provisions of~~ s. 163.340(7) or s. (8)(a)-(o) ~~(8)(a)-(n)~~ or do not contain properties that are protected by deed restrictions. Such ordinance may be amended or repealed in the same manner as other local ordinances.

Section 4. This act shall take effect July 1, 2015.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Community Affairs, *Chair*
Environmental Preservation and Conservation, *Vice Chair*
Appropriations Subcommittee on General Government
Finance and Tax
Judiciary
Transportation

JOINT COMMITTEE:
Joint Legislative Auditing Committee

SENATOR WILTON SIMPSON
18th District

February 17, 2015

Honorable Lizbeth Benacquisto
Committee on Banking and Insurance
320 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chairman Benacquisto,

Please place Senate Bill 404 relating to sinkhole activity, on the next Banking and Insurance Committee agenda.

Please contact my office with any questions. Thank you.

Wilton Simpson
Senator, 18th District

CC: James Knudson, Staff Director

REPLY TO:
- 322 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5018
- Post Office Box 938, Brooksville, Florida 34605
- Post Office Box 787, New Port Richey, Florida 34656-0787 (727) 816-1120 FAX: (888) 263-4821

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

851116

LEGISLATIVE ACTION

Senate . House

. .

. .

. .

. .

The Committee on Banking and Insurance (Montford) recommended the following:

Senate Amendment

Delete line 205

and insert:

assessments pursuant to paragraph (a) or paragraph (e)

548084

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Montford) recommended the following:

Senate Amendment

Delete line 232
and insert:
association

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 836
INTRODUCER:	Senator Latvala
SUBJECT:	Florida Insurance Guaranty Association
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			CM	
3.			FP	
4.				
5.				
6.				

I. Summary:

SB 836 revises provisions governing the Florida Insurance Guaranty Association (FIGA), which provides a mechanism for the payment of covered claims, including unearned premiums, of insolvent property and casualty insurance companies. After an insolvency occurs, FIGA determines if an assessment is needed to pay claims, administrative costs, or bonds issued by FIGA and certifies the need for an assessment levy to the Office of Insurance Regulation (OIR). The OIR reviews the certification, and if it is sufficient, the OIR issues an order to all insurance companies subject to the FIGA assessment to pay their assessment to FIGA. Generally, insurers must pay regular assessments within 30 days of the levy, and emergency assessments can be paid in a single payment, or over 12 months, at the option of FIGA. For both types of assessments, once an insurance company pays the assessment to FIGA, it may begin to recoup the assessment from its policyholders at the policy issuance or renewal.

The bill creates a uniform assessment percentage to be collected from policyholders. The bill authorizes FIGA to use a monthly installment method for the collection of emergency or regular assessments from insurers in addition to the current pay and recoup method or a combination of both. An insurer that did not write insurance in the prior year is required to pay an assessment based on an estimate of premiums it will write in the assessment year. The bill streamlines the reconciliation of collections and eliminates a regulatory filing with the OIR. The bill codifies the OIR's interpretation of an admissible asset for purposes of statutory accounting treatment of FIGA assessments.

The bill exempts regular assessments from the insurance premium tax. Currently, emergency assessments are exempt from the insurance premium tax.

II. Present Situation:

Florida Insurance Guaranty Association

Part II of chapter 631, Florida Statutes governs the operations of the Florida Insurance Guaranty Association (FIGA), a nonprofit corporation, which was created to provide a mechanism for the payment of covered claims, including unearned premiums, of insolvent property and casualty insurance companies.[1] Property and casualty insurance companies doing business in Florida are required to be a member of FIGA as a condition of their authority to transact insurance. When a property and casualty insurance company becomes insolvent, FIGA is required to assume the claims of the insurer and pay the claims of the company's policyholders, which includes claims on residential and commercial property insurance, automobile insurance, and liability insurance, among others.

The maximum claim amount FIGA will cover is $300,000, but special limits apply to damages to structure and contents on homeowners, condominiums, and homeowners' association claims. For damages to the structure and contents on homeowners' claims, FIGA covers an additional $200,000, for a total of $500,000. For condominium and homeowners' association claims, FIGA covers the lesser of policy limits or $100,000 multiplied by the number of units in the association.

FIGA Funding and Assessments

In order to pay the remaining covered claims and maintain the operations of an insolvent insurer, FIGA has several potential funding sources. For example, FIGA receives funds that are available from distributions of the estate of the insolvent insurance company.[2] FIGA also obtains funds from the liquidation of assets of insolvent insurers domiciled in other states, but having claims in Florida.

After an insolvency occurs, FIGA is authorized to levy assessments against Florida member insurance companies under two separate statutory provisions. Under s. 631.57(3)(a), F.S., FIGA is authorized to levy a regular assessment as necessary for up to 2 percent of an insurer's net written premium for the kind of insurance included in the account for which the assessment is levied. The second assessment is an emergency assessment authorized under s. 631.57(3)(e), F.S., which may be levied only to pay covered claims of an insurer that was rendered insolvent by the effects of a hurricane. At the discretion of FIGA, emergency assessments are payable in 12 monthly installments or in a single payment. The emergency assessment is capped at 2 percent of an insurer's net direct written premiums in Florida for the calendar year preceding the assessment.

The procedure used by FIGA to levy both regular and emergency assessments on member insurance companies and the procedure used by member insurance companies to pass the

[1] Workers' compensation insurance is excluded from FIGA since the Florida Workers' Compensation Insurance Guaranty Association (FWCIGA) pays covered claims under chapter 440, F.S., Florida's Workers' Compensation Law.
[2] The Division of Rehabilitation and Liquidation in the Department of Financial Services is responsible for the liquidation of assets of insolvent insurance companies.

assessment on to their policyholders is provided in s. 631.57(3), F.S. The procedures are generally the same for regular and emergency assessments:

1. FIGA determines that an assessment is needed to pay claims or administration costs, or to pay bonds issued by FIGA.
2. FIGA certifies the need for an assessment levy to the OIR.
3. The OIR reviews the certification, and if it is sufficient, the OIR issues an order to all insurance companies subject to the FIGA assessment to pay their assessment to FIGA.
4. Insurers must pay regular assessments within 30 days of the levy. Emergency assessments can be either paid in one payment at the end of that month, or spread out over 12 months, at the option of FIGA.
5. For both types of assessments, once an insurance company pays the assessment to FIGA, it may begin to recoup the assessment from its policyholders at the policy issuance or renewal.

An insurer must submit an informational filing to the OIR at least 15 days before applying the recoupment factor to any policies. The factor is applied to policies issued or renewed by the insurer for 1 year under the affected lines of insurance. The 15-day requirement also applies if the insurer needs to continue applying the recoupment factor for an additional year. The factor is calculated to provide for the probable recoupment of assessments over a 1-year period, unless an insurer elects to recoup the assessment over a longer period. If the excess amount does not exceed 15 percent of the total assessment paid, the excess amount is remitted to FIGA within 60 days after the end of the 1-year period in which the excess recoupment charges were collected. Any excess recoupments remitted to FIGA are used to reduce future assessments. If the excess amount exceeds 15 percent of the total assessment paid, the excess amount is required to be returned to an insurer's current policyholder by refunds or premium credits.

Accounting for Assessments

Most insurers authorized to do business in the United States are required by their state regulators to prepare financial statements in accordance with statutory accounting principles (SAP). These principles are tools that assist state insurance departments in the regulation of the solvency. SAP is characterized as a conservative approach since it evaluates liquidity and the ability to pay claims in the future. In contrast, other users of financial information, such as shareholders, bondholders, banks, credit rating agencies, and the Securities and Exchange Commission, may require financial statements that are prepared in accordance with generally accepted accounting principles (GAAP), which attempt to match revenues to expenses. The OIR requires insurers to file annual SAP statements and independently audited financial reports.[3]

In some respects, GAAP differs from SAP in the treatment of certain transactions, such as the FIGA assessments. Under both accounting methods, a liability is recognized. However, SAP allows the recognition of an asset for the amount that is likely to be recovered from future premium surcharges for an assessment, which offsets or eliminates the negative effect on statutory surplus.[4] For purposes of GAAP, the assessment recoverable from future premium writings does not qualify as an asset, resulting in a reduction of retained earnings in the period an assessment is levied. The impact of the assessment on GAAP financial statements is essentially a

[3] Section 624.424, F.S.

[4] *See* Thomas Howell Ferguson P.A., *Accounting for Guaranty Fund Assessments,* memorandum to Sandy Robinson at FIGA, December 3. 2013, (on file with the Senate Committee on Banking and Insurance).

timing issue; retained earnings are reduced in the year the assessment is paid; however, it is increased the following year as the assessment is recouped from policyholders. The OIR requires that assessments levied before policy surcharges are collected result in a receivable, which must be recognized as an admissible asset[5] under SAP, to the extent the receivable is likely to be realized.[6]

Insurance Premium Tax

The premium tax is applied to insurance premiums written in Florida. For purposes of property and casualty insurance premiums, the tax is 1.75 percent on gross premiums less reinsurance and returned premiums.[7] An insurance company may offset their premium tax liability with various credits, deductions, and exemptions. Amounts recouped from policyholders because of a regular assessment by FIGA relating to an insolvency that occurs on or after July 1, 2010, are considered taxable premium under s. 624.509, F.S.[8] Emergency assessments recouped by insurers are not considered taxable premiums.[9]

III. Effect of Proposed Changes:

The bill significantly revises the assessment process for regular and emergency assessments.

Section 1 amends s. 631.54, F.S., to define "assessment year," as a 12-month period, which may begin on the first day of any calendar quarter, as specified in an order issued by the OIR directing insurers to pay an assessment to FIGA.

Section 2 amends s. 631.57, F.S. In the OIR order levying the regular or emergency assessment, the bill requires the office to specify the assessment percentage to be collected uniformly from all assessable policyholders for the assessment year. The order must also specify the start of the assessment year, which may not begin before 90 days after FIGA certifies such an assessment.

Under the initial or single payment method, insurers are required to make an initial payment to FIGA before the beginning of the assessment year, on or before the date specified in the order. The initial payment made by insurers that wrote insurance in the preceding calendar year is based on the net direct written premiums of the prior year multiplied by the uniform percentage. The initial payment made by insurers that did not write in the prior calendar year is based on a good faith estimate of the anticipated net direct written premium that would be written for the assessment year, multiplied by the uniform percentage of premium. Currently, an insurer's market share for the prior year is used as a basis for determining an insurer's total assessment, and insurers that did not write in the prior year are not subject to the assessment.

Subsequently, insurers are required to file a reconciliation report with FIGA within 45 days after the end of the assessment year, indicating the amount of the initial payment to FIGA, whether the

[5] As defined in the National Association of Insurance Commissioners' Statement of Statutory Accounting Principles No. 4.
[6] Office of Insurance Regulation, Supplemental Memorandum to Information Memorandum OIR-06-023M (Dec. 1, 2006). http://www.floir.com/siteDocuments/SupplementalMemo.pdf (Last accessed by Banking and Insurance Committee Staff on February 10, 2015).
[7] Section 624.509, F.S.
[8] Section 631.57(3)(g). F.S.
[9] Section 631.57(3)(e)3., F.S.

payment was based on premiums for the prior year or a good faith projection, and the amounts collected. Reconciliation reports are subject to s. 626.9541(1)(e), F.S., which specifies that knowing, false statements and entries are an unfair insurance trade practice. Insurers are required to complete and submit a payment reconciliation report. If an insurer's collections exceed the initial payment to FIGA, the insurer would remit the excess amount to FIGA within 90 days after the end of the assessment year. If an insurer's collections were less than the initial payment to FIGA, FIGA would credit the insurer that amount against future assessments. Under the current collection method, an insurer generally remits the regular assessment within 30 days of the levy.

As an alternative to the advance payment method described above, the bill authorizes FIGA to use a monthly installment method for the collection of regular or emergency assessments from policyholders by the insurers. The monthly installment method may also be used in combination with the method requiring insurers to make an initial payment to FIGA and subsequently recoup that payment from policyholders. Currently, FIGA is authorized to use a single payment method or payments over 12 months for emergency assessments. The bill provides FIGA with the discretion to use the installment plan based on FIGA's projected cash flow. If FIGA projects that it has cash on hand for the payment of expected claims in the applicable account for 6 months, FIGA may recommend a monthly assessment instead of a single payment. In the order levying the assessment, the OIR may specify that the assessment is due and payable monthly as the funds are collected from insureds throughout the assessment year. If the assessment is due and payable monthly, the assessment must be a uniform percentage of premium collected from all policyholders with policies in the classes protected by the account. All insurers are required to collect the assessment without regard to whether the insurer reported premium for the prior year.

The bill provides that assessments levied under s. 631.57(3), F.S., are levied upon insurers and that this subsection does not create a cause of action by a policyholder with respect to the levying of, or a policyholders duty to pay, such assessments. The bill retains the current caps on assessments of 2 percent for the regular assessment and 2 percent for the emergency assessment.

The bill authorizes the OIR to defer temporarily any insurer from any regular or temporary assessment if the OIR finds that the insurer is impaired or insolvent. Currently, s. 631.57(4), F.S., provides a limited exception to the assessment. Subject to regulatory approval, an insurer may be exempted from any regular or emergency assessment if an assessment would result in the insurer's financial statement reflecting an amount of capital or surplus less than the sum required by any jurisdiction in which the insurer is authorized to transact insurance.

The bill provides that assessments levied and paid before policy surcharges are collected result in a receivable for policy surcharges collected in the future, which is recognized as an admissible asset under statutory accounting principles,[10] to the extent the receivable is likely to be realized. This codifies the current practice of the OIR. The bill provides that an asset must be established and recorded separately from the liability, regardless of whether it is based on a retrospective or prospective premium-based assessment. The insurer must reduce the amount recorded as an asset if it cannot fully recoup the assessment amount because of a reduction in writings or withdrawal from the market. For assessments that are paid after policy surcharges are collected pursuant to

[10] National Association of Insurance Commissioners' Statement of Statutory Accounting Principles No. 4.

the monthly installment method, the recognition of assets would be based on the actual premium written offset by the obligation to FIGA.

The bill provides that assessments are exempt from the premium tax. Currently, emergency assessments are not subject to premium tax, commissions, or fees. The bill also exempts regular assessments from any fees or commissions.

Section 3 amends s. 631.64, F.S., to require the separate disclosures of charges or recoupments on premium statements.

Sections 4 and 5 provide technical, conforming changes.

Section 6 provides the bill will take effect July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Indeterminate. The bill exempts the emergency assessment from insurance premium tax.

B. Private Sector Impact:

The bill would allow FIGA to use a single payment, monthly installment plan, or a combination of methods for the collection of regular and emergency assessments. Currently, FIGA may collect regular or emergency assessments upfront from insurers and FIGA has the option to collect the emergency assessment over 12 months.

The bill creates a uniform percentage assessment percentage of policyholders. The assessment would apply to insurers writing in the preceding year and new insurers writing insurance as of, or after the date FIGA certifies the assessment. Under the current method, the amount of assessment is based on the market share of insurers for the prior year and insurers that did not write in the prior year but are currently writing are not subject to an assessment.

The bill streamlines the assessment recoupment, reconciliation, and reporting process for insurers by requiring insurers to file a reconciliation report and a payment reconciliation report with FIGA. The bill eliminates the requirement that an insurer must file an informational statement with the OIR prior to applying a recoupment factor on policies.

Advocates of the bill contend that the current assessment mechanism poses a threat to the solvency of property insurers doing business in Florida after a storm. Advocates of the bill state that a monthly payment reduces the risk of insolvency.

The bill exempts the regular assessment from the insurance premium tax.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 631.54, 631.57, 631.64, 627.727, and 631.55.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Latvala

20-00549B-15 2015836__

A bill to be entitled

An act relating to the Florida Insurance Guaranty Association; amending s. 631.54, F.S.; defining the term "assessment year"; amending s. 631.57, F.S.; revising provisions relating to the levy of assessments on insurers by the Florida Insurance Guaranty Association; specifying conditions under which such assessments are paid; revising procedures and timeframes for the levying of the assessments; revising provisions relating to assessments that are premium and not subject to the premium tax; limiting an insurer's liability for uncollectible emergency assessments; deleting the requirement to file a final accounting report documenting the recoupment; revising an exemption for assessments; amending s. 631.64, F.S.; requiring charges or recoupments to be displayed separately on premium statements to policyholders and prohibiting their inclusion in rates; amending ss. 627.727 and 631.55, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsections (2) through (9) of section 631.54, Florida Statutes, are renumbered as subsections (3) through (10), respectively, and a new subsection (2) is added to that section to read:

631.54 Definitions.—As used in this part:

(2) "Assessment year" means the 12-month period, which may

20-00549B-15 2015836__

begin on the first day of any calendar quarter, whether January 1, April 1, July 1, or October 1, as specified in an order issued by the office directing insurers to pay an assessment to the association.

Section 2. Subsections (3) and (4) of section 631.57, Florida Statutes, are amended to read:

631.57 Powers and duties of the association.—

(3)(a) To the extent necessary to secure ~~the~~ funds for the respective accounts for the payment of covered claims, to pay the reasonable costs to administer such accounts ~~the same~~, and ~~to the extent necessary~~ to secure ~~the~~ funds for the account specified in s. 631.55(2)(b) or to retire indebtedness, including, without limitation, the principal, redemption premium, if any, and interest on, and related costs of issuance of, bonds issued under s. 631.695 and the funding of ~~any~~ reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, the office, upon certification of the board of directors, shall levy assessments, in accordance with subparagraphs (f)1. or 2., initially estimated in the proportion that each insurer's net direct written premiums in this state in the classes protected by the account bears to the total of said net direct written premiums received in this state by all such insurers for the preceding calendar year for the kinds of insurance included within such account. Assessments shall be remitted to and administered by the board of directors in the manner specified by the approved plan and paragraph (f). Each insurer so assessed shall have at least 30 days' written notice as to the date the initial assessment payment is due and

payable. Every assessment shall be ~~made as~~ a uniform percentage ~~applicable to the net direct written premiums of each insurer in the kinds of insurance included within the account in which the assessment is made~~. The assessments levied against any insurer may ~~shall~~ not exceed in any one calendar year more than 2 percent of that insurer's net direct written premiums in this state for the kinds of insurance included within such account ~~during the calendar year next preceding the date of such assessments~~.

(b) If sufficient funds from such assessments, together with funds previously raised, are not available in any one year in the respective account to make all the payments or reimbursements then owing to insurers, the funds available shall be prorated and the unpaid portion ~~shall be~~ paid as soon ~~thereafter~~ as funds become available.

(c) The Legislature finds and declares that all assessments paid by an insurer or insurer group as a result of a levy by the office, including assessments levied pursuant to paragraph (a) and emergency assessments levied pursuant to paragraph (e), constitute advances of funds from the insurer to the association. An insurer may fully recoup such advances by applying the uniform assessment percentage levied by the office to all ~~a separate recoupment factor to the premium of~~ policies of the same kind or line as were considered by the office in determining the assessment liability of the insurer or insurer group as set forth in paragraph (f).

1. Assessments levied under subparagraph (f)1. are paid before policy surcharges are collected and result in a receivable for policy surcharges collected in the future. This

amount, to the extent it is likely that it will be realized, meets the definition of an admissible asset as specified in the National Association of Insurance Commissioners' Statement of Statutory Accounting Principles No. 4. The asset shall be established and recorded separately from the liability regardless of whether it is based on a retrospective or prospective premium-based assessment. If an insurer is unable to fully recoup the amount of the assessment because of a reduction in writings or withdrawal from the market, the amount recorded as an asset shall be reduced to the amount reasonably expected to be recouped.

2. Assessments levied under subparagraph (f)2. are paid after policy surcharges are collected so that the recognition of assets is based on actual premium written offset by the obligation to the association.

(d) ~~No~~ State funds may not ~~of any kind shall~~ be allocated or paid to the ~~said~~ association or any of its accounts.

(e)1.~~a.~~ In addition to assessments ~~otherwise~~ authorized in paragraph (a), and to the extent necessary to secure the funds for the account specified in s. 631.55(2)(b) for the direct payment of covered claims of insurers rendered insolvent by the effects of a hurricane and to pay the reasonable costs to administer such claims, or to retire indebtedness, including, without limitation, the principal, redemption premium, if any, and interest on, and related costs of issuance of, bonds issued under s. 631.695 and the funding of any reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, the office, upon certification of the board of directors, shall levy emergency

assessments upon insurers holding a certificate of authority. The emergency assessments levied against ~~payable under this paragraph by~~ any insurer may ~~shall~~ not exceed in any one calendar ~~single~~ year more than 2 percent of that insurer's net ~~direct~~ written premiums~~, net of refunds,~~ in this state ~~during the preceding calendar year~~ for the kinds of insurance within the account specified in s. 631.55(2)(b).

2.~~b.~~ ~~Any~~ Emergency assessments authorized under this paragraph shall be levied by the office upon insurers in accordance with subparagraph (f) ~~referred to in sub-subparagraph a.~~, upon certification as to the need for such assessments by the board of directors. If ~~In the event~~ the board ~~of directors~~ participates in the issuance of bonds in accordance with s. 631.695, emergency assessments shall be levied in each year that bonds issued under s. 631.695 and secured by such emergency assessments are outstanding~~,~~ in ~~such~~ amounts up to such 2-percent limit as required in order to provide for the full and timely payment of the principal of, redemption premium, if any, and interest on, and related costs of issuance of, such bonds. The emergency assessments ~~provided for in this paragraph~~ are assigned and pledged to the municipality, county, or legal entity issuing bonds under s. 631.695 for the benefit of the holders of such bonds~~,~~ in order ~~to enable such municipality, county, or legal entity~~ to provide for the payment of the principal of, redemption premium, if any, and interest on such bonds, the cost of issuance of such bonds, and the funding of any reserves and other payments required under the bond resolution or trust indenture pursuant to which such bonds have been issued, without ~~the necessity of any~~ further action by the

association, the office, or any other party. If ~~To the extent~~ bonds are issued under s. 631.695 and the association determines to secure such bonds by a pledge of revenues received from the emergency assessments, such bonds, upon such pledge of revenues, shall be secured by and payable from the proceeds of such emergency assessments, and the proceeds of emergency assessments levied under this paragraph shall be remitted directly to and administered by the trustee or custodian appointed for such bonds.

3.~~c.~~ Emergency assessments used to defease bonds issued under this part ~~paragraph~~ may be payable in a single payment or, at the option of the association, may be payable in 12 monthly installments with the first installment being due and payable at the end of the month after an emergency assessment is levied and subsequent installments being due by ~~not later than~~ the end of each succeeding month.

4.~~d.~~ If emergency assessments are imposed, the report required by s. 631.695(7) must ~~shall~~ include an analysis of the revenues generated from the emergency assessments imposed under this paragraph.

5.~~e.~~ If emergency assessments are imposed, the references in sub-subparagraph (1)(a)3.b. and s. 631.695(2) and (7) to assessments levied under paragraph (a) must ~~shall~~ include emergency assessments imposed under this paragraph.

6.~~2.~~ If the board of directors participates in the issuance of bonds in accordance with s. 631.695, an annual assessment under this paragraph shall continue while the bonds issued with respect to which the assessment was imposed are outstanding, including any bonds the proceeds of which were used to refund

bonds issued pursuant to s. 631.695, unless adequate provision has been made for the payment of the bonds in the documents authorizing the issuance of such bonds.

~~3. Emergency assessments under this paragraph are not premium and are not subject to the premium tax, to any fees, or to any commissions. An insurer is liable for all emergency assessments that the insurer collects and shall treat the failure of an insured to pay an emergency assessment as a failure to pay the premium. An insurer is not liable for uncollectible emergency assessments.~~

(f) ~~The recoupment factor applied to policies in accordance with paragraph (c) shall be selected by the insurer or insurer group so as to provide for the probable recoupment of both assessments levied pursuant to paragraph (a) and emergency assessments over a period of 12 months, unless the insurer or insurer group, at its option, elects to recoup the assessment over a longer period. The recoupment factor shall apply to all policies of the same kind or line as were considered by the office in determining the assessment liability of the insurer or insurer group issued or renewed during a 12-month period. If the insurer or insurer group does not collect the full amount of the assessment during one 12-month period, the insurer or insurer group may apply recalculated recoupment factors to policies issued or renewed during one or more succeeding 12-month periods. If, at the end of a 12-month period, the insurer or insurer group has collected from the combined kinds or lines of policies subject to assessment more than the total amount of the assessment paid by the insurer or insurer group, the excess amount shall be disbursed as follows:~~

1. The association, office, and insurers remitting emergency assessments pursuant to paragraph (a) or paragraph (e) must comply with the following:

a. In the order levying an assessment, the office shall specify the actual percentage amount to be collected uniformly from all the policyholders of insurers subject to the assessment and the date on which the assessment year begins, which may not begin before 90 days after the association board certifies such an assessment.

b. Insurers shall make an initial payment to the association before the beginning of the assessment year on or before the date specified in the order of the office.

c. Insurers that have written insurance in the calendar year before the year in which the assessment is certified by the board shall make an initial payment based on the net direct written premium amount from the previous calendar year as set forth in the insurers annual statement, multiplied by the uniform percentage of premium specified in the order issued by the office. Insurers that have not written insurance in the previous calendar year in any of the lines under the account which are being assessed, but which are writing insurance as of, or after, the date the board certifies the assessment to the office, shall pay an amount based on a good faith estimate of the amount of net direct written premium anticipated to be written in the subject lines of business for the assessment year, multiplied by the uniform percentage of premium specified in the order issued by the office.

d. Insurers shall file a reconciliation report with the association within 45 days after the end of the assessment year

which indicates the amount of the initial payment to the association before the assessment year, whether such amount was based on net direct written premium contained in a previous calendar year annual statement or a good faith projection, the amount actually collected during the assessment year, and such other information contained on a form adopted by the association and provided to the insurers in advance. If the insurer collected from policyholders more than the amount initially paid, the insurer shall pay the excess amount to the association. If the insurer collected from policyholders an amount which is less than the amount initially paid to the association, the association shall credit the insurer that amount against future assessments. Such payment reconciliation report, and any payment of excess amounts collected from policyholders, shall be completed and remitted to the association within 90 days after the end of the assessment year. The association shall send a final reconciliation report on all insurers to the office within 120 days after each assessment year.

e. Insurers remitting reconciliation reports under this paragraph to the association are subject to s. 626.9541(1)(e). ~~If the excess amount does not exceed 15 percent of the total assessment paid by the insurer or insurer group, the excess amount shall be remitted to the association within 60 days after the end of the 12-month period in which the excess recoupment charges were collected.~~

2. For assessments required under paragraph (a) or paragraph (e), the association may use a monthly installment method instead of the method described in sub-subparagraphs 1.b.

and c. or in combination thereof based on the association's projected cash flow. If the association projects that it has cash on hand for the payment of anticipated claims in the applicable account for at least 6 months, the board may make an estimate of the assessment needed and may recommend to the office the assessment percentage that may be collected as a monthly assessment. The office may, in the order levying the assessment on insurers, specify that the assessment is due and payable monthly as the funds are collected from insureds throughout the assessment year, in which case the assessment shall be a uniform percentage of premium collected during the assessment year and shall be collected from all policyholders with policies in the classes protected by the account. All insurers shall collect the assessment without regard to whether the insurers reported premium in the year preceding the assessment. Insurers are not required to advance funds if the association and the office elect to use the monthly installment option. All funds collected shall be retained by the association for the payment of current or future claims. This subparagraph does not alter the obligation of an insurer to remit assessments levied pursuant to this subsection to the association. ~~If the excess amount exceeds 15 percent of the total assessment paid by the insurer or insurer group, the excess amount shall be returned to the insurer's or insurer group's current policyholders by refunds or premium credits. The association shall use any remitted excess recoupment amounts to reduce future assessments.~~

(g) ~~Amounts recouped pursuant to this subsection for assessments levied under paragraph (a) due to insolvencies on or~~

~~after July 1, 2010, are considered premium solely for premium tax purposes and are not subject to fees or commissions. However,~~ Insurers shall treat the failure of an insured to pay a recoupment charge as a failure to pay the premium.

(h) Assessments levied under this subsection are levied upon insurers. This subsection does not create a cause of action by a policyholder with respect to the levying of, or a policyholder's duty to pay, such assessments.

(i) Assessments levied under this subsection are not premium and are not subject to the premium tax, to any fees, or to any commissions. An insurer is liable for any emergency assessments that the insurer collects and shall treat the failure of an insured to pay an emergency assessment as a failure to pay the premium. An insurer is not liable for uncollectible emergency assessments.

~~(h) At least 15 days before applying the recoupment factor to any policies, the insurer or insurer group shall file with the office a statement for informational purposes only setting forth the amount of the recoupment factor and an explanation of how the recoupment factor will be applied. Such statement shall include documentation of the assessment paid by the insurer or insurer group and the arithmetic calculations supporting the recoupment factor. The insurer or insurer group may use the recoupment factor at any time after the expiration of the 15-day period. The insurer or insurer group need submit only one informational statement for all lines of business using the same recoupment factor.~~

~~(i) No later than 90 days after the insurer or insurer group has completed the recoupment process, the insurer or~~

~~insurer group shall file with the office, for information purposes only, a final accounting report documenting the recoupment. The report shall provide the amounts of assessments paid by the insurer or insurer group, the amounts and percentages recouped by year from each affected line of business, and the direct written premium subject to recoupment by year. The insurer or insurer group need submit only one report for all lines of business using the same recoupment factor.~~

(4) The office ~~department~~ may exempt or temporarily defer any insurer from any regular or emergency assessment if the office finds that the insurer is impaired or insolvent or if an assessment would result in such insurer's financial statement reflecting an amount of capital or surplus less than the sum of the minimum amount required by any jurisdiction in which the insurer is authorized to transact insurance.

Section 3. Section 631.64, Florida Statutes, is amended to read:

631.64 Recognition of assessments ~~in rates~~.—Charges or recoupments shall be separately displayed on premium statements to enable policyholders to determine the amount charged for association assessments but may not be included in rates filed and approved by the office. ~~The rates and premiums charged for insurance policies to which this part applies may include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association, and such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member~~

~~insurer.~~

Section 4. Subsection (5) of section 627.727, Florida Statutes, is amended to read:

627.727 Motor vehicle insurance; uninsured and underinsured vehicle coverage; insolvent insurer protection.—

(5) Any person having a claim against an insolvent insurer as defined in s. 631.54~~(6)~~ under ~~the provisions of~~ this section shall present such claim for payment to the Florida Insurance Guaranty Association only. In the event of a payment to a ~~any~~ person in settlement of a claim arising under ~~the provisions of~~ this section, the association is not subrogated or entitled to ~~any~~ recovery against the claimant's insurer. The association, however, has the rights of recovery as set forth in chapter 631 in the proceeds recoverable from the assets of the insolvent insurer.

Section 5. Subsection (1) of section 631.55, Florida Statutes, is amended to read:

631.55 Creation of the association.—

(1) There is created a nonprofit corporation to be known as the "Florida Insurance Guaranty Association, Incorporated." All insurers defined as member insurers in s. 631.54~~(7)~~ shall be members of the association as a condition of their authority to transact insurance in this state, and, further, as a condition of such authority, an insurer must ~~shall~~ agree to reimburse the association for all claim payments the association makes on the ~~said~~ insurer's behalf if such insurer is subsequently rehabilitated. The association shall perform its functions under a plan of operation established and approved under s. 631.58 and shall exercise its powers through a board of directors

established under s. 631.56. The corporation shall have all those powers granted or permitted nonprofit corporations, as provided in chapter 617.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Transportation, Tourism, and Economic Development, *Chair*
Appropriations
Commerce and Tourism
Governmental Oversight and Accountability
Regulated Industries
Rules

SENATOR JACK LATVALA
20th District

March 2, 2015

The Honorable Lizbeth Benaquisto, Chair
Senate Committee on Banking and Insurance
320 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Benaquisto:

I respectfully request consideration of Senate Bill 836/Florida Insurance Guaranty Association by the Senate Banking and Insurance Committee at your earliest convenience.

This bill clarifies current law allowing for FIGA to spread out the timing of the collection of funds. This will address some of the burdens relating to the assessments required of hundreds of companies and also assist the Office of Insurance Regulation with their workload.

If you have any questions regarding this legislation, please contact me. Thank you in advance for your consideration.

Sincerely,

Jack Latvala
State Senator
District 20

Cc: James Knudson, Staff Director; Sheri Green, Administrative Assistant

REPLY TO:
❒ 26133 U.S. Highway 19 North, Suite 201, Clearwater, Florida 33763 (727) 793-2797 FAX: (727) 793-2799
❒ 408 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5020

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

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LEGISLATIVE ACTION

Senate . House

. . . . . .

The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment

Delete lines 66 - 272
and insert:
provide that such refund will be paid from one of the following sources of proceeds:
a. The proceeds of the next entrance fees received by the provider for units for which there are no prior claims by any resident until paid in full;
b. The proceeds of the next entrance fee received by the

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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

c. The proceeds of the next entrance fee received by the provider for the unit that is vacated if the contract is approved by the office before October 1, 2015. A provider 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~~, if the provider has discontinued marketing continuing care contracts, within 200 days after the date of notice~~.

3. For contracts entered into on or after January 1, 2016, that provide for a refund in accordance with sub-subparagraph 2.b., the following provisions apply:

a. 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 must be paid by the earlier of:

(I) 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

(II) Within 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.

b. Any refund that is due to a resident who vacates the unit and voluntarily terminates a contract after the 7-day rescission period required in subsection (2) must be paid within 30 days after receipt by the provider of the next entrance fee

for a like or similar unit for which there are no prior claims by any resident until paid in full and is not subject to the provisions in sub-subparagraph a. A contract is voluntarily terminated when a resident provides written notice of intent to leave and moves out of the continuing care facility after the 7-day rescission period.

4. For purposes of this paragraph, the term "like or similar unit" means 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 as specified in the residency or reservation contract. Each category must consist of at least 5 percent of the total number of residential units designated for independent living or 10 residential units designated for independent living, whichever is less. However, a group of units consisting of single family homes may contain fewer than 10 units.

5. If the provider has discontinued marketing continuing care contracts, any refund due a resident must be paid within 200 days after the contract is terminated and the unit is vacated.

6.~~4.~~ Unless subsection (5) applies, for any prospective resident, regardless of whether or not such a resident receives a transferable membership or ownership right in the facility, who cancels the contract before occupancy of the unit, the entire amount paid toward the entrance fee shall be refunded, less a processing fee of up to 5 percent of the entire entrance fee; however, the processing fee may not exceed the amount paid by the prospective resident. Such refund must be paid within 60

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days after the resident gives ~~giving~~ notice of intention to cancel. For a resident who has occupied his or her unit and who has received a transferable membership or ownership right in the facility, the foregoing refund provisions do not apply but are deemed satisfied by the acquisition or receipt of a transferable membership or an ownership right in the facility. The provider may not charge any fee for the transfer of membership or sale of an ownership right.

(i) ~~(h)~~ State the terms under which a contract is canceled by the death of the resident. These terms may contain a provision that, upon the death of a resident, the entrance fee of such resident is considered earned and becomes the property of the provider. If the unit is shared, the conditions with respect to the effect of the death or removal of one of the residents must be included in the contract.

(j) ~~(i)~~ Describe the policies that may lead to changes in monthly recurring and nonrecurring charges or fees for goods and services received. The contract must provide for advance notice to the resident, of at least 60 days, before any change in fees or charges or the scope of care or services is effective, except for changes required by state or federal assistance programs.

(k) ~~(j)~~ Provide that charges for care paid in one lump sum may not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs.

(l) ~~(k)~~ Specify whether the facility is, or is affiliated with, a religious, nonprofit, or proprietary organization or management entity; the extent to which the affiliate organization will be responsible for the financial and

contractual obligations of the provider; and the provisions of the federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of federal income tax.

Section 2. Section 651.028, Florida Statutes, is amended to read:

651.028 Accredited facilities.—If a provider is accredited without stipulations or conditions by a process found by the office to be acceptable and substantially equivalent to the provisions of this chapter, the office may, pursuant to rule of the commission, waive any requirements of this chapter with respect to the provider if the office finds that such waivers are not inconsistent with the security protections intended by this chapter.

Section 3. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

(1) In the event of bankruptcy, receivership, or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider shall be deemed preferred claims against all assets owned by the provider; however, such claims are subordinate to ~~those priority claims set forth in s. 631.271 and~~ any secured claim.

Section 4. Subsections (4) and (5) of section 651.105, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

651.105 Examination and inspections.—

(4) The office shall notify the provider and the executive

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officer of the governing body of the provider in writing of all deficiencies in its compliance with the provisions of this chapter and the rules adopted pursuant to this chapter and shall set a reasonable length of time for compliance by the provider. In addition, the office shall require corrective action or request a corrective action plan from the provider which plan demonstrates a good faith attempt to remedy the deficiencies by a specified date. If the provider fails to comply within the established length of time, the office may initiate action against the provider in accordance with the provisions of this chapter.

(5) At the time of the routine examination, the office shall determine if all disclosures required under this chapter have been made to the president or chair of the residents' council and the executive officer of the governing body of the provider.

(6) A representative of the provider must give a copy of the final examination report and corrective action plan, if one is required by the office, to the executive officer of the governing body of the provider within 60 days after issuance of the report.

Section 5. Section 651.081, Florida Statutes, is amended to read:

651.081 Residents' council.—

(1) Residents living in a facility holding a valid certificate of authority under this chapter have the right of self-organization, the right to be represented by an individual of their own choosing, and the right to engage in concerted activities for the purpose of keeping informed on the operation

of the facility that is caring for them or for the purpose of other mutual aid or protection.

(2)(a) Each facility shall establish a residents' council created for the purpose of representing residents on matters set forth in s. 651.085. The residents' council shall ~~may~~ be established through an election in which the residents, as defined in s. 651.011, vote by ballot, physically or by proxy. If the election is to be held during a meeting, a notice of the organizational meeting must be provided to all residents of the community at least 10 business days before the meeting. Notice may be given through internal mailboxes, communitywide newsletters, bulletin boards, in-house television stations, and other similar means of communication. An election creating a residents' council is valid if at least 40 percent of the total resident population participates in the election and a majority of the participants vote affirmatively for the council. The initial residents' council created under this section is valid for at least 12 months. A residents' organization formalized by bylaws and elected officials must be recognized as the residents' council under this section and s. 651.085. Within 30 days after the election of a newly elected president or chair of the residents' council, the provider shall give the president or chair a copy of this chapter and rules adopted thereunder, or direct him or her to the appropriate public website to obtain this information. Only one residents' council may represent residents before the governing body of the provider as described in s. 651.085(2).

(b) In addition to those matters provided in s. 651.085, a residents' council shall provide a forum in which a resident may

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submit issues or make inquiries related to, but not limited to, subjects that impact the general residential quality of life and cultural environment. The residents' council shall serve as a formal liaison to provide input related to such matters to the appropriate representative of the provider.

(c) The activities of a residents' council are independent of the provider. The provider is not responsible for ensuring, or for the associated costs of, compliance of the residents' council with the provisions of this section with respect to the operation of a residents' council.

(d) A residents' council shall adopt its own bylaws and governance documents. The residents' council shall provide for open meetings when appropriate. The governing documents shall define the manner in which residents may submit an issue to the council and define a reasonable timeframe in which the residents' council shall respond to a resident submission or inquiry. A residents' council may include term limits in its governing documents to ensure consistent integration of new leaders. If a licensed facility files for bankruptcy under chapter 11 of the United States Bankruptcy Code, 11 U.S.C. chapter 11, the facility, in its required filing of the 20 largest unsecured creditors with the United States Trustee, shall include the name and contact information of a designated resident selected by the residents' council and a statement explaining that the designated resident was chosen by the residents' council to serve as a representative of the residents' interest on the creditors' committee.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1126
INTRODUCER:	Senator Altman
SUBJECT:	Continuing Care Communities
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Knudson	BI	**Pre-meeting**
2.			AGG	
3.			FP	

I. Summary:

SB 1126 revises laws governing continuing care retirement communities (CCRCs), which are facilities that provide shelter and nursing care or personal services to residents upon the payment of an entrance fee.

The bill requires continuing care facilities to provide refunds of entrance fees within 90 days after the continuing care contract is terminated and the unit is vacated, instead of within 120 days of the notice to cancel as under current law. The provision applies to contracts entered into on or after January 1, 2016, and contract addendums that are approved by the Office of Insurance Regulation (OIR). The bill requires continuing care contracts to specify one of three sources of payment for refunds paid from the proceeds of subsequent entrance fees and prohibits refunds conditioned on receipt of the entrance fee for the same unit as of October 1, 2016. The bill also requires the contract include a statutorily required time frame for the refund of an entrance fee in specified circumstances if the entrance fee refund will be paid from the proceeds of the next entrance fee for a like or similar unit.

The bill requires CCRCs to establish residents' councils, whose activities must be independent of the CCRC. Currently, the formation of a residents councils is optional. The bill requires each residents' council to designate a resident to represent them before the governing body of the provider.

The bill specifies that continuing care and continuing care at-home contracts are preferred claims in a bankruptcy, receivership, or liquidation and are subordinate only to secured claims.

The bill revises notice requirements related to examination reports and any related corrective action plan and disclosure requirements for third-party audits of the CCRC.

II. Present Situation:

Continuing Care Retirement Communities

A continuing care facility provides shelter and nursing care or personal services to residents upon the payment of an entrance fee.[1] According to representatives of the CCRCs, continuing care facilities generally feature apartment style independent living units, assisted living units, and nursing care, typically all on a single campus.[2] Many also offer assisted living, memory support care, and other specialty care arrangements.[3] These facilities also provide residents with dining options, housekeeping, security, transportation, social and recreational activities, and wellness and fitness programs.[4] Continuing care facilities may also offer at-home programs that provide residents CCRC services while continuing to live in their own homes until they are ready to move to the CCRC.[5] In addition to the entrance fee, a CCRC also generally charge residents monthly fees to cover costs related to health care and other aspects of community living. [6]

There are currently 71 licensed continuing care retirement communities in Florida.[7] Continuing care retirement communities are spread throughout the state, with Palm Beach County, Sarasota County, and Pinellas County having the greatest numbers of these communities. Almost 25,000 residents lived in a CCRC during 2013.

Oversight responsibility of these entities is shared primarily between the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR). The Agency for Health Care Administration regulates aspects of CCRCs related to the provision of health care such as assisted living, skilled nursing care, quality of care, and concerns with medical facilities. Because residents pay, in some cases, considerable amounts in entrance fees and ongoing monthly fees, there is a need to ensure that CCRCs are in the proper financial and managerial position to provide services to present and future residents. Accordingly, the Office of Insurance Regulation (OIR) is given primary responsibility to authorize and monitor the operation of facilities and to determine facilities' financial status and the management capabilities of their managers and owners.[8] If a continuing care provider is accredited through a process substantially equivalent to the requirements of chapter 651, F.S., the office may waive requirements of that chapter.[9] The Department of Financial Services (DFS) may become involved after a contractual agreement has been signed by both parties or during a mediation process. These matters are usually initially addressed through DFS's Consumer Helpline.

In order to operate a CCRC in Florida, a provider must obtain from OIR a certificate of authority predicated upon first receiving a provisional certificate.[10] The application process involves

[1] Section 651.011, F.S.
[2] Jane E. Zarem, *Today's Continuing Care Retirement Community*, pg. 2 (July 2010).
[3] Zarem, *supra* note 2, at 2.
[4] Zarem, *supra* note 2, at 2.
[5] Section 651.057, F.S.
[6] About Continuing Care Retirement Communities, AARP.org, http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/ho_continuing_care_retirement_communities.html (last visited March 7, 2015).
[7] Office of Insurance Regulation, *Presentation to the Governor's Continuing Care Advisory Council* (September 29, 2014).
[8] See ss. 651.021 and 651.023, F.S.
[9] Section 651.028, F.S.
[10] Section 651.022, F.S.

submitting a market feasibility study and various financial information, including projected revenues and expenses, current assets and liabilities of the applicant, and expectations of the financial condition of the project.[11] A certificate of authority will only be issued once a provider submits proof that a minimum of 50 percent of the units available have been reserved.[12]

Continuing Care Retirement Community Contracts

Continuing care services are governed by a contract between the facility and the resident of a CCRC. In Florida, continuing care contracts are considered an insurance product and are reviewed and approved for the market by OIR.[13] 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 set out by the provider.
- List all property transferred to the facility by the resident upon moving to the CCRC, including amounts paid or payable by the resident.
- Specify all services to be provided by the provider to each resident, including, but not limited to, food, shelter, personal services, nursing care, drugs, burial and incidentals.
- Describe the terms and conditions for cancellation of the contract given a variety of circumstances.
- Describe all other relevant terms and conditions included in statute.[14]

The entrance fee is an initial or deterred payment made as full or partial payment for continuing care.[15] According to CCRC providers, entrance fees typically are strongly correlated to local housing prices, though they range widely.[16] Generally, entrance fees range from $100,000 to $1 million.[17] Under Florida law, a continuing care contract must specify the terms governing the refund of any portion of the entrance fee.[18] A CCRC facility may only retain up to 2 percent of the entrance fee per month of resident occupancy along with a processing fee of up to 5 percent.[19] If the continuing care contract provides that the facility will only retain up to 1 percent of the entrance fee per month, the contract may also provide that the refund will be paid from the proceeds of the next entrance fees received by the provider,[20] or, if the provider is no longer marketing CCRC contracts, within 200 days after the date of notice.[21] If the contract is cancelled before the unit is occupied, the entire entrance fee must be refunded other than a processing fee of up to 5 percent of the entire entrance fee.[22] Florida law requires the contract to specify the terms under which a contract is cancelled due to the resident's death, which may include a provision allowing the CCRC provider to retain the entire entrance fee.[23]

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[11] See ss. 651.021-651.023, F.S.
[12] Section 651.023(4)(a), F.S.
[13] Section 651.055(1), F.S.
[14] *Id*.
[15] See s. 651.011(5), F.S.
[16] Zarem, *supra* note 2, at 9.
[17] About Continuing Care Retirement Communities, AARP.org, http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/ho_continuing_care_retirement_communities.html (last visited March 7, 2015).
[18] Section 651.055(1)(g)1., F.S.
[19] Section 651.055(1)(g)2., F.S.
[20] For units for which there are not prior resident claims.
[21] Section 651.055(1)(g)3., F.S.
[22] Section 651.055(1)(g)4., F.S.
[23] Section 651.055(1)(h), F.S.

Rights of Residents in a Continuing Care Retirement Community

The OIR is also empowered to discipline a facility for violations of residents' rights.[24] These rights include: a right to live in a safe and decent living environment, free from abuse and neglect; freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community; present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal.[25]

Current law requires CCRCs to hold quarterly meetings at which residents' organizations may be represented.[26] The meetings are for the purpose of holding a free discussion of subjects such as the facility's income, expenditures, financial trends, and problems, as well as proposed changes in policies, programs, and services. If the CCRC proposes the imposition or increase of a monthly maintenance fee, additional duties are placed on the CCRC provider to provide notice and give reasons for the proposed action.

Residents of a CCRC may form a residents' council for the purpose of representing residents in quarterly meetings with the CCRC provider.[27] Florida law provides a process by which a residents' council is formed. The residents' council must be created by a vote in which at least 40 percent of the total resident population participates and a majority of the participants vote in favor of creating the council.[28] A residents' council may designate a resident to represent them before the governing body of the provider.[29] The residents' council representative must be invited to participate in the portion of any meeting of the full governing body of the CCRC during which proposed changes in resident fees or services will be discussed.[30]

If the OIR institutes receivership or liquidation proceedings against a CCRC, the continuing care contracts are deemed preferred claims against assets of the provider.[31] Such claims are subordinate, however, to any secured claim and the priority claims detailed in s. 631.271, F.S. Florida law does not specify the claim status of continuing care contracts in a bankruptcy proceeding.

III. Effect of Proposed Changes:

Refunds of Entrance Fees at Cancellation of Continuing Care Contracts

Section 1 amends s. 651.055, F.S., to revise the statutory requirements for refunding portions of entrance fees to residents who do not have a transferrable membership or ownership right in the continuing care facility.

[24] Section 651.083, F.S.
[25] *Id*.
[26] Section 651.085, F.S.
[27] Section 651.081, F.S.
[28] Section 651.081(2), F.S.
[29] Section 651.085(2), F.S.
[30] Section 651.085(3), F.S.
[31] Section 651.071, F.S.

The bill requires continuing care facilities to provide refunds of entrance fees within 90 days after the continuing care contract is terminated and the unit is vacated, instead of within 120 days of the notice to cancel under current law. The provision applies to all contracts entered into on or after January 1, 2016. For contracts entered into before that date, the continuing care resident may execute a contract addendum approved by OIR providing for a refund within 90 days. The bill does not change the requirement that CCRC providers may only retain up to 2 percent of the entrance fee per month of occupancy by the resident.

If the continuing care contract provides for the CCRC to retain no more than 1 percent per month of resident occupancy, current law allows continuing care contracts to specify that an entrance fee refund will be paid from the proceeds of the next entrance fee received by the CCRC for which there are no prior claims. The bill requires continuing care contracts to specify one of three sources of payment for the refund:

- The entrance fee refund will be paid from the proceeds of the next entrance fee;
- The entrance fee refund will be paid from the proceeds of the next entrance fee for a like or similar unit[32] for which there are no prior claims; or
- The entrance fee refund will be paid from the proceeds of the next entrance fee for the unit being vacated. This option may only be used until October 1, 2016. The option is allowed until October 1, 2016, because there are CCRCs that currently have this option in their contracts. Such CCRCs must submit to the OIR for approval by August 2, 2016, a new or amended contract that uses one of the other refund options.

The bill also requires the contract to specify the following time frames for the refund of an entrance fee if the continuing care contract specifies that the entrance fee refund will be paid from the proceeds of the next entrance fee for a like or similar unit:

- If the refund is due upon the resident's death or relocation to another level of care that results in termination of the CCRC contract, the refund must be made the earlier of 30 days after the CCRC receives the next entrance fee for a like or similar unit or within a specified maximum number of months or years, as specified by the contract.
- If the refund is due because the resident vacates the unit and voluntarily terminates[33] the contract after the 7-day rescission period, the refund must be paid within 30 days after the CCRC receives the next entrance fee for a like or similar unit for which there are no prior claims.

If the CCRC is not marketing continuing care contracts, refunds must be paid within 200 days after the contract terminates and the unit is vacated.

Waiver of Continuing Care Facility Requirements

Section 2 amends s. 651.028, F.S., to limit OIR authority to waive requirements placed on accredited CCRCs by ch. 651, F.S. The bill specifies that a waiver may only be given to a CCRC that is accredited without stipulations or conditions. The bill maintains current law allowing only

[32] The bill defines "like or similar unit" as a category that has similar characteristics including comparable square footage, number of bedrooms, or location. Each such category must contain at least 5 percent of the total number of residential units or, if the units are not single family homes, at least 10 units.

[33] Under the bill, a continuing care contract is voluntarily terminated when a resident provides written notice of intent to leave and moves out of the CCRC after the 7-day rescission period.

those waivers that are consistent with the security protections of the chapter. The only requirement typically waived by the OIR is the requirement to submit quarterly financial reports.[34]

Priority of Claims at Bankruptcy, Receivership, or Liquidation

Section 3 amends s. 651.071, F.S., to specify that continuing care and continuing care at-home contracts are preferred claims in a bankruptcy, subordinate only to secured claims. It is uncertain the extent to which the amendment will affect the rulings of federal bankruptcy courts regarding priority of claims. The bill also deletes current law specifying that in a receivership or liquidation proceeding, CCRC contract claims are subordinate to the priority claims listed in s. 631.271, F.S., related to the estate of an insurer. Current law makes such contracts preferred claims in a liquidation or receivership, but subordinates them to secured claims and the priority claims listed in s. 631.271, F.S.

Residents' Councils and Quarterly Meetings

Section 5 amends s. 651.081, F.S., to require each CCRC to establish a residents' council, which must be established through an election by the residents. Under current law, it is optional both to establish a residents' council and to do so through the election process outlined in statute.

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 residents' council must provide a forum for residents to submit issues or make inquiries, particularly on matters that impact the general residential quality of life and cultural environment of the CCRC. The council 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 CCRC 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.

Section 6 amends s. 651.085, F.S., to require the OIR to request verification from each CCRC that required quarterly meetings between the CCRC governing body or designated representative and the residents are held and open to all residents. Currently, the OIR is only required to request verification upon receiving a complaint from the residents' council.

[34] See Office of Insurance Regulation, *Senate Bill 1126 Agency Analysis* (March 3, 2015) (on file with the Senate Committee on Banking and Insurance).

The bill also requires the residents' council to designate a resident to represent them before the governing body of the provider. A licensed CCRC provider may allow a resident of a facility to be a voting member of the board of directors or governing body of the CCRC, and may establish criteria for the selection of that resident. If the board or governing body of a licensed CCRC provider operates more than one facility, it may select a resident from among its facilities to serve on the board or governing body on a rotating basis.

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

Section 4 amends s. 651.105, F.S., to require the OIR to provide notice to the CCRC executive officer of all compliance deficiencies identified by the OIR in an examination. The bill also directs the OIR to determine during each routine examination whether all required disclosures have been made to the CCRC executive officer. A representative of the provider must give a copy of the OIR final examination report and any corrective action plan to the executive officer of the CCRC governing body within 60 days after report issuance.

Section 7. amends s. 651.091, F.S., to require each CCRC to distribute a copy of the most recent third-party financial audit filed with the annual report to the president or chair of the residents' council within 30 days after filing the annual report with the OIR. The CCRC must also designate a staff person to provide an explanation of the audit.

Effective Date

Section 8 provides an effective date of October 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Residents of CCRC communities that enter bankruptcy, receivership, or liquidation may benefit from continuing care contracts being made priority claims subordinate only secured claims.

C. Government Sector Impact:

The Office of Insurance Regulation and the Department of Children and Families each determined that the bill does not fiscally impact their respective agencies.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 651.055, 651.028, 651.071, 651.105, 651.081, 651.085, and 651.091.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Altman

16-00687-15 20151126__

A bill to be entitled

An act relating to continuing care communities; amending s. 651.055, F.S.; revising requirements for continuing care contracts; amending s. 651.028, F.S.; revising authority of the Office of Insurance Regulation to waive requirements for accredited facilities; amending s. 651.071, F.S.; providing that continuing care and continuing care at-home contracts are preferred claims in the event of bankruptcy proceedings against a provider; revising subordination of claims; amending s. 651.105, F.S.; revising notice requirements; revising duties of the office; requiring an agent of a provider to provide a copy of an examination report and corrective action plan under certain conditions; amending s. 651.081, F.S.; requiring a residents' council to provide a forum for certain purposes; requiring a residents' council to adopt its own bylaws and governance documents; amending s. 651.085, F.S.; revising provisions relating to quarterly meetings between residents and the governing body of the provider; revising powers of the residents' council; amending s. 651.091, F.S.; revising continuing care facility reporting requirements; providing an effective date.

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

Section 1. Paragraphs (g) through (k) of subsection (1) of section 651.055, Florida Statutes, are amended to read:

16-00687-15 20151126__

651.055 Continuing care contracts; right to rescind.—

(1) Each continuing care contract and each addendum to such contract shall be submitted to and approved by the office before its use in this state. Thereafter, no other form of contract shall be used by the provider until it has been submitted to and approved by the office. Each contract must:

(g) Provide that the contract may be canceled by giving at least 30 days' written notice of cancellation by the provider, the resident, or the person who provided the transfer of property or funds for the care of such resident. However, if a contract is canceled because there has been a good faith determination that a resident is a danger to himself or herself or others, only such notice as is reasonable under the circumstances is required.

(h)~~1.~~ Describe ~~The contract must also provide~~ in clear and understandable language, in print no smaller than the largest type used in the body of the contract, the terms governing the refund of any portion of the entrance fee.

1.~~2.~~ For a resident whose contract with the facility provides that the resident does not receive a transferable membership or ownership right in the facility, and who has occupied his or her unit, the refund shall be calculated on a pro rata basis with the facility retaining up to 2 percent per month of occupancy by the resident and up to a 5 percent processing fee. Such refund must be paid within 120 days after giving the notice of intention to cancel. For contracts entered into on or after January 1, 2016, refunds must be made within 90 days after the contract is terminated and the unit is vacated. A resident who enters into a contract before January 1, 2016, may

voluntarily sign a contract addendum approved by the office that provides for a revised refund requirement.

2.~~3.~~ In addition to a processing fee not to exceed 5 percent, if the contract provides for the facility to retain no more than ~~up to~~ 1 percent per month of occupancy by the resident and the resident does not receive a transferable membership or ownership right in the facility, the contract shall~~, it may~~ provide that such refund will be paid from:

a. The proceeds of the next entrance fees received by the provider for units for which there are no prior claims by any resident until paid in full;

b. 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

c. Effective October 1, 2016, the proceeds of the next entrance fee received by the provider for the unit that is vacated if the contract is approved by the office before October 1, 2015. In order to use the refund option in this sub-subparagraph, the provider must submit a new or amended contract with an alternative refund provision to the office for approval by August 2, 2016~~, if the provider has discontinued marketing continuing care contracts, within 200 days after the date of notice~~.

3. For contracts entered into on or after January 1, 2016, that provide for a refund in accordance with sub-subparagraph 2.b., the following provisions apply:

a. 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 must be paid by the earlier of:

(I) 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

(II) Within 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.

b. Any refund that is due to a resident who vacates the unit and voluntarily terminates a contract after the 7-day rescission period required in subsection (2) must be paid within 30 days after receipt by the provider of the next entrance fee for a like or similar unit for which there are no prior claims by any resident until paid in full and is not subject to the provisions in sub-subparagraph a. A contract is voluntarily terminated when a resident provides written notice of intent to leave and moves out of the continuing care facility after the 7-day rescission period.

4. For purposes of this paragraph, the term "like or similar unit" means a residential dwelling categorized into a group of units which have similar characteristics, including comparable square footage, number of bedrooms, location, age of construction, or a combination of one or more of these features as specified in the residency or reservation contract. Each category must consist of at least 5 percent of the total number of residential units designed for independent living or 10 residential units designated for independent living, whichever is less. However, a group of units consisting of single family

homes may contain fewer than 10 units.

5. If the provider has discontinued marketing continuing care contracts, any refund due a resident must be paid within 200 days after the contract is terminated and the unit is vacated.

6.~~4.~~ Unless subsection (5) applies, for any prospective resident, regardless of whether or not such a resident receives a transferable membership or ownership right in the facility, who cancels the contract before occupancy of the unit, the entire amount paid toward the entrance fee shall be refunded, less a processing fee of up to 5 percent of the entire entrance fee; however, the processing fee may not exceed the amount paid by the prospective resident. Such refund must be paid within 60 days after the resident gives ~~giving~~ notice of intention to cancel. For a resident who has occupied his or her unit and who has received a transferable membership or ownership right in the facility, the foregoing refund provisions do not apply but are deemed satisfied by the acquisition or receipt of a transferable membership or an ownership right in the facility. The provider may not charge any fee for the transfer of membership or sale of an ownership right.

(i)~~(h)~~ State the terms under which a contract is canceled by the death of the resident. These terms may contain a provision that, upon the death of a resident, the entrance fee of such resident is considered earned and becomes the property of the provider. If the unit is shared, the conditions with respect to the effect of the death or removal of one of the residents must be included in the contract.

(j)~~(i)~~ Describe the policies that may lead to changes in

monthly recurring and nonrecurring charges or fees for goods and services received. The contract must provide for advance notice to the resident, of at least 60 days, before any change in fees or charges or the scope of care or services is effective, except for changes required by state or federal assistance programs.

(k)~~(j)~~ Provide that charges for care paid in one lump sum may not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs.

(l)~~(k)~~ Specify whether the facility is, or is affiliated with, a religious, nonprofit, or proprietary organization or management entity; the extent to which the affiliate organization will be responsible for the financial and contractual obligations of the provider; and the provisions of the federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of federal income tax.

Section 2. Section 651.028, Florida Statutes, is amended to read:

651.028 Accredited facilities.—If a provider is accredited without stipulations or conditions by a process found by the office to be acceptable and substantially equivalent to the provisions of this chapter, the office may, pursuant to rule of the commission, waive any requirements of this chapter with respect to the provider if the office finds that such waivers are not inconsistent with the security protections intended by this chapter.

Section 3. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

(1) In the event of bankruptcy, receivership, or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider shall be deemed preferred claims against all assets owned by the provider; however, such claims are subordinate to ~~those priority claims set forth in s. 631.271 and~~ any secured claim.

Section 4. Subsections (4) and (5) of section 651.105, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

651.105 Examination and inspections.—

(4) The office shall notify the provider and the executive officer of the governing body of the provider in writing of all deficiencies in its compliance with the provisions of this chapter and the rules adopted pursuant to this chapter and shall set a reasonable length of time for compliance by the provider. In addition, the office shall require corrective action or request a corrective action plan from the provider which plan demonstrates a good faith attempt to remedy the deficiencies by a specified date. If the provider fails to comply within the established length of time, the office may initiate action against the provider in accordance with the provisions of this chapter.

(5) At the time of the routine examination, the office shall determine if all disclosures required under this chapter have been made to the president or chair of the residents' council and the executive officer of the governing body of the provider.

(6) A representative of the provider must give a copy of the final examination report and corrective action plan, if one is required by the office, to the lead officer of the governing body of the provider within 60 days after issuance of the report.

Section 5. Section 651.081, Florida Statutes, is amended to read:

651.081 Residents' council.—

(1) Residents living in a facility holding a valid certificate of authority under this chapter have the right of self-organization, the right to be represented by an individual of their own choosing, and the right to engage in concerted activities for the purpose of keeping informed on the operation of the facility that is caring for them or for the purpose of other mutual aid or protection.

(2)(a) Each facility shall establish a residents' council created for the purpose of representing residents on matters set forth in s. 651.085. The residents' council shall ~~may~~ be established through an election in which the residents, as defined in s. 651.011, vote by ballot, physically or by proxy. If the election is to be held during a meeting, a notice of the organizational meeting must be provided to all residents of the community at least 10 business days before the meeting. Notice may be given through internal mailboxes, communitywide newsletters, bulletin boards, in-house television stations, and other similar means of communication. An election creating a residents' council is valid if at least 40 percent of the total resident population participates in the election and a majority of the participants vote affirmatively for the council. The

initial residents' council created under this section is valid for at least 12 months. A residents' organization formalized by bylaws and elected officials must be recognized as the residents' council under this section and s. 651.085. Within 30 days after the election of a newly elected president or chair of the residents' council, the provider shall give the president or chair a copy of this chapter and rules adopted thereunder, or direct him or her to the appropriate public website to obtain this information. Only one residents' council may represent residents before the governing body of the provider as described in s. 651.085(2).

(b) In addition to those matters provided in s. 651.085, a residents' council shall provide a forum in which a resident may submit issues or make inquiries related to, but not limited to, subjects that impact the general residential quality of life and cultural environment. The residents' council shall serve as a formal liaison to provide input related to such matters to the appropriate representative of the provider.

(c) The activities of a residents' council are independent of the provider. The provider is not responsible for ensuring, or for the associated costs of, compliance of the residents' council with the provisions of this section with respect to the operation of a residents' council.

(d) A residents' council shall adopt its own bylaws and governance documents. The residents' council shall provide for open meetings when appropriate. The governing documents shall define the manner in which residents may submit an issue to the council and define a reasonable timeframe in which the residents' council shall respond to a resident submission or

inquiry. A residents' council may include term limits in its governing documents to ensure consistent integration of new leaders. If a licensed facility files for bankruptcy under chapter 11 of the United States Bankruptcy Code, 11 U.S.C. chapter 11, the facility, in its required filing with the United States Trustee, shall include the 20 largest unsecured creditors, the name and contact information of a designated resident selected by the residents' council, and 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, if appropriate.

Section 6. Section 651.085, Florida Statutes, is amended to read:

651.085 Quarterly meetings between residents and the governing body of the provider; resident representation before the governing body of the provider.—

(1) The governing body of a provider, or the designated representative of the provider, shall hold quarterly meetings with the residents of the continuing care facility for the purpose of free discussion of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility, as well as a discussion on proposed changes in policies, programs, and services. At quarterly meetings where monthly maintenance fee increases are discussed, a summary of the reasons for raising the fee as specified in subsection (4) must be provided in writing to the president or chair of the residents' council. Upon request of the residents' council, a member of the governing body of the provider, such as a board member, general partner, principal

owner, or designated representative shall attend such meetings. Residents are entitled to at least 7 days' advance notice of each quarterly meeting. An agenda and any materials that will be distributed by the governing body or representative of the provider shall be posted in a conspicuous place at the facility and shall be available upon request to residents of the facility. The office shall request verification from a facility that quarterly meetings are held and open to all residents ~~if it receives a complaint from the residents' council that a facility is not in compliance with this subsection~~. In addition, a facility shall report to the office in the annual report required under s. 651.026 the dates on which quarterly meetings were held during the reporting period.

(2) A residents' council formed pursuant to s. 651.081, members of which are elected by the residents, shall ~~may~~ designate a resident to represent them before the governing body of the provider ~~or organize a meeting or ballot election of the residents to determine whether to elect a resident to represent them before the governing body of the provider. If a residents' council does not exist, any resident may organize a meeting or ballot election of the residents of the facility to determine whether to elect a resident to represent them before the governing body and, if applicable, elect the representative. The residents' council, or the resident that organizes a meeting or ballot election to elect a representative, shall give all residents notice at least 10 business days before the meeting or election. Notice may be given through internal mailboxes, communitywide newsletters, bulletin boards, in-house television stations, and other similar means of communication. An election~~

~~of the representative is valid if at least 40 percent of the total resident population participates in the election and a majority of the participants vote affirmatively for the representative.~~ The initial designated representative elected under this section shall be elected to serve at least 12 months.

(3) The designated representative shall be notified at least 14 days in advance of any meeting of the full governing body at which proposed changes in resident fees or services will be discussed. The representative shall be invited to attend and participate in that portion of the meeting designated for the discussion of such changes.

(4) At a quarterly meeting prior to the implementation of any increase in the monthly maintenance fee, the designated representative of the provider must provide the reasons, by department cost centers, for any increase in the fee that exceeds the most recently published Consumer Price Index for All Urban Consumers, all items, Class A Areas of the Southern Region. Nothing in this subsection shall be construed as placing a cap or limitation on the amount of any increase in the monthly maintenance fee, establishing a presumption of the appropriateness of the Consumer Price Index as the basis for any increase in the monthly maintenance fee, or limiting or restricting the right of a provider to establish or set monthly maintenance fee increases.

(5) The board of directors or governing board of a licensed provider may at its sole discretion allow a resident of the facility to be a voting member of the board or governing body of the facility. The board of directors or governing board of a licensed provider may establish specific criteria for the

nomination, selection, and term of a resident as a member of the board or governing body. If the board or governing body of a licensed provider operates more than one licensed facility, regardless of whether the facility is in-state or out-of-state, the board or governing body may select at its sole discretion one resident from among its facilities to serve on the board of directors or governing body on a rotating basis.

Section 7. Paragraph (d) of subsection (2) of section 651.091, Florida Statutes, is amended to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(d) Distribute a copy of the full annual statement and a copy of the most recent third-party financial audit filed with the annual report to the president or chair of the residents' council within 30 days after filing the annual report with the office, and designate a staff person to provide explanation thereof.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Military and Veterans Affairs, Space, and Domestic Security, *Chair*
Children, Families, and Elder Affairs, *Vice-Chair*
Appropriations
Appropriations Subcommittee on General Government
Environmental Preservation and Conservation
Finance and Tax

SENATOR THAD ALTMAN
16th District

March 3, 2015

The Honorable Lizbeth Benacquisto
Senate Committee on Banking and Insurance, Chair
320 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

Dear Madame Chair Benacquisto:

I respectfully request that SB 1126, related to *Continuing Care Communities*, be placed on the committee agenda at your earliest convenience.

Thank you for your consideration, and please do not hesitate to contact me should you have any questions.

Sincerely,

Thad Altman

CC: James Knudson, Staff Director, 320 Knott Building
Sheri Green, Committee Administrative Assistant

TA/rak

REPLY TO:
❒ 8710 Astronaut Blvd, Cape Canaveral, FL 32920 (321) 752-3138
❒ 314 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5016

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

591894

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Lee) recommended the following:

Senate Amendment (with title amendment)

Delete lines 71 - 96
and insert:
Section 2. Section 472.0366, Florida Statutes, is created to read:
472.0366 Elevation certificates; requirements for surveyors and mappers.—
(1) As used in this section, the term:
(a) "Division" means the Division of Emergency Management

591894

established within the Executive Office of the Governor under s. 14.2016.

(b) "Elevation certificate" means the certificate used to demonstrate the elevation of property which has been developed by the Federal Emergency Management Agency pursuant to federal floodplain management regulation or which is completed by a surveyor and mapper.

(2) An elevation certificate must be completed by a surveyor and mapper in accordance with the checklist developed by the division. Within 30 days after the completion of an elevation certificate, a surveyor and mapper must submit a copy of the certificate to the division. The copy must be unaltered, except that the surveyor and mapper may redact the name of the property owner.

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

And the title is amended as follows:

Delete lines 6 - 16

and insert:

472.0366, F.S.; defining terms; requiring a surveyor and mapper to complete an elevation certificate in accordance with a checklist developed by the Division of Emergency Management and to submit a copy of the elevation certificate to the division within a certain time after its completion; authorizing the redaction of certain personal information from the copy; amending s. 627.715, F.S.; revising

657366

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Lee) recommended the following:

Senate Amendment (with title amendment)

Delete lines 128 - 150
and insert:
3. Customized flood insurance must include coverage that is broader than the coverage provided under standard flood insurance.
4. Flexible flood insurance must cover losses from the peril of flood, as defined in paragraph (b), and may also include coverage for losses from water intrusion originating

657366

from outside the structure which is not otherwise covered by the definition of flood. Flexible flood insurance must include one or more of the following provisions:

a. An agreement between the insurer and the insured that the flood coverage is in a specified amount, such as coverage that is limited to the total amount of each outstanding mortgage applicable to the covered property.

b. A requirement for a deductible in an amount authorized under s. 627.701, including a deductible in an amount authorized for hurricanes.

c. A requirement that flood loss to a dwelling be adjusted in accordance with s. 627.7011(3) or adjusted only on the basis of the actual cash value of the property.

d. A restriction limiting flood coverage to the principal building defined in the policy.

e. A provision including or excluding coverage for additional living expenses.

f. A provision excluding coverage for personal property or contents as to the peril of flood.

Flexible flood insurance must be acceptable to the mortgage lender if such policy, contract, or endorsement is intended to satisfy a mortgage requirement.

5.~~4.~~ Supplemental flood insurance may provide coverage

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

And the title is amended as follows:

Delete lines 16 - 19

657366

and insert:

by the division; amending s. 627.715, F.S.; authorizing flexible flood insurance; specifying coverage requirements; requiring such insurance to be acceptable to the mortgage lender if intended to satisfy a mortgage requirement; deleting a provision

611562

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Lee) recommended the following:

Senate Amendment (with title amendment)

Delete line 198
and insert:
excessive, inadequate, or unfairly discriminatory. If the office determines that a rate is excessive or unfairly discriminatory, the office shall require the insurer to provide appropriate credit to affected insureds.

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

611562

And the title is amended as follows:

Delete line 24

and insert:

flood insurance policy; requiring the Office of Insurance Regulation to require an insurer to provide appropriate credit to affected insureds if the office determines that a rate of the insurer is excessive or unfairly discriminatory; requiring an agent to offer a

114946

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Lee) recommended the following:

Senate Amendment (with title amendment)

Delete lines 216 - 223

and insert:

(8) An agent must, upon receiving ~~obtaining~~ an application for flood

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

And the title is amended as follows:

Delete lines 24 - 29

114946

and insert:

flood insurance policy; revising the

748102

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Lee) recommended the following:

Senate Amendment (with title amendment)

Delete lines 245 - 256

and insert:

(11)(a) An authorized insurer offering flood insurance may request the office to certify that a policy, contract, or endorsement provides coverage for the peril of flood which equals or exceeds the flood coverage offered by the National Flood Insurance Program. To be eligible for certification, such policy, contract, or endorsement must contain a provision

748102

stating that it meets the private flood insurance requirements specified in 42 U.S.C. s. 4012a(b) and may not contain any provision that is not in compliance with 42 U.S.C. s. 4012a(b).

(b) The authorized insurer or its agent may reference or include a certification under paragraph (a) in advertising or communications with an agent, a lending institution, an insured, or a potential insured only for a policy, contract, or endorsement that is certified under this subsection. The authorized insurer may include a statement that notifies an insured of the certification on the declarations page or other policy documentation related to flood coverage certified under this subsection.

(c) An insurer or agent who knowingly misrepresents that a flood policy, contract, or endorsement is certified under this subsection commits an unfair or deceptive act under s. 626.9541.

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

And the title is amended as follows:

Delete lines 40 - 42

and insert:

Program; specifying requirements for such certification; authorizing such insurer or its agent to reference or include the certification in specified advertising, communications, and documentation; providing that misrepresenting that a flood policy, contract, or endorsement is certified is an unfair or deceptive act;

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1094
INTRODUCER:	Senator Brandes
SUBJECT:	Peril of Flood
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow/Knudson	Knudson	BI	**Pre-meeting**
2.			CA	
3.			RC	

I. Summary:

SB 1094 requires coastal management plans to include the reduction of flood risks and losses, creates new requirements related to flood elevation certificates, and revises requirements related to flood insurance.

The bill requires local governments when drafting their comprehensive coastal management plan must include development and redevelopment principles, strategies, and engineering solutions that reduce flood risks and losses within coastal areas.

Elevation certificates developed by the Federal Emergency Management Agency (FEMA) will be required to be completed by a licensed surveyor and mapper in accordance with the checklist that has been adopted by the Division of Emergency Management (DEM). A surveyor and mapper who completes an elevation certificate must, within 30 days of completion, submit a copy of the certificate to the property appraiser office in the county in which the property that was evaluated resides. The bill requires DEM to establish a schedule in which property appraisers are required to regularly submit copies of the elevation certificates they have received from licensed surveyors and mappers.

The bill revises the requirements for customized flood insurance by eliminating the requirement that such coverage be broader than standard or preferred flood coverage. Customized coverage instead is defined as coverage for the peril of flood that differs from standard or preferred coverage by:

- Being in an agreed upon amount between the insurer and policyholder.
- Including a deductible as authorized in s. 627.701, F.S.
- Being adjusted in accordance with s. 627.7011(3), F.S., or adjusted only on the basis of the actual cash value of the property.
- 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.

The bill removes current law prohibiting a supplemental flood insurance policy from being used for excess coverage over any other insurance policy covering the peril of flood. The bill clarifies that the declarations or face page a flood insurance policy must promptly note the deductibles and coverage limits of the policy.

The bill requires all licensed insurance agents must quote a flood insurance policy when quoting an insurance policy for a residential structure located within a Special Flood Hazard Area. The bill also allows an insurer to request from the Office of Insurance Regulation (OIR) a certification that acknowledges that the insurer provides a flood policy, contract, or endorsement that equals or exceeds flood coverage by the National Flood Insurance Program.

II. Present Situation:

National Flood Insurance Program

The NFIP was created by the passage of the National Flood Insurance Act of 1968.[1] The NFIP is administered by the Federal Emergency Management Agency (FEMA) and provides property owners located in flood-prone areas the ability to purchase flood insurance protection from the federal government. Flood insurance through the NFIP is only available in communities that adopt and enforce federal floodplain management criteria.[2]

Standard NFIP Flood Insurance

The standard flood insurance policy dwelling form offered by the NFIP[3] is a single peril flood policy that pays for direct physical damage to the insured residential property up to the replacement cost[4] (RCV) or actual cash value (ACV) or the policy limit.[5] The maximum coverage limit for a NFIP standard flood insurance policy is $250,000. The NFIP also offers up to $100,000 in personal property (contents) coverage, which is always valued at ACV.[6] Most NFIP policies also include Increased Cost of Compliance (ICC) coverage of up to $30,000 of the cost to comply with state or community floodplain management laws or ordinances after a flood

[1] http://www.fema.gov/media-library/assets/documents/7277?id=2216 (Last accessed by staff on January 2, 2014)
[2] *National Flood Insurance Program: Program Description*, pgs. 2-4., Federal Emergency Management Agency/Federal Insurance and Mitigation Administration (August 1, 2002) http://www.fema.gov/media-library/assets/documents/1150?id=1480 (Last accessed by staff on January 7, 2014).
[3] 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.
[4] 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.
[5] *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 accessed by staff on January 7, 2014).
[6] See footnote 4.

in which a building has been declared substantially damaged or repetitively damaged.[7] The maximum coverage available to a condominium association is $250,000 per unit multiplied by the total number of units.[8] The limits of coverage for NFIP flood insurance on non-residential buildings are $500,000 in coverage to the building and $500,000 in contents coverage.[9]

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.[10]

The minimum deductibles for NFIP flood coverage are:

- For properties built before the effective date of the first Flood Insurance Rate Map[11] (FIRM) for a community, the minimum deductible is:
  - $1,500 if the property is insured for $100,000 or less.
  - $2,000 if the property is insured for over $100,000.
- For properties built after the effective date of the first Flood Insurance Rate Map (FIRM) for a community, the minimum deductible is:
  - $1,000 if the property is insured for $100,000 or less.
  - $1,250 if the property is insured for over $100,000.

Federal Requirements to Obtain Flood Insurance

The U.S. Congress passed the Flood Disaster Protection Act in 1973.[12] The Act mandated property owners with mortgages issued by federally regulated or insured lenders must purchase flood insurance if their properties are located in Special Flood Hazard Areas. Special Flood Hazard Areas are defined by FEMA as high-risk areas where there is at least a one in four chance of flooding during a 30-year mortgage.[13]

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[7] The total amount of a building claim and ICC claim cannot exceed the maximum limit for building property coverage. For a single-family home, this is the $250,000 maximum limit on coverage to the building. See footnote 4 and footnote 5 at page 26.

[8] *FDIC Compliance Manual*, V – 6.8. http://www.fdic.gov/regulations/compliance/manual/index.html (Last accessed by staff on January 7, 2014).

[9] *Reducing Damage from Localized Flooding: A Guide for Communities*, 11-2. http://www.fema.gov/media-library/assets/documents/1012 (Last accessed by staff on January 7, 2014).

[10] http://www.fema.gov/national-flood-insurance-program/definitions (Last accessed by staff on January 2, 2014)

[11] The effective date of the first FIRM for Florida communities can be found at http://www.fema.gov/cis/FL.pdf (Last accessed by staff on January 10, 2014).

[12] http://www.fema.gov/media-library-data/20130726-1545-20490-9247/frm_acts.pdf (Last accessed by staff on January 2, 2014).

[13] http://www.floodsmart.gov/floodsmart/pages/flooding_flood_risks/defining_flood_risks.jsp (Last accessed by staff on January 2, 2014).

The National Flood Insurance Reform Act of 1994[14] (1994 Reform Act) required federal financial regulatory agencies[15] to revise their flood insurance regulations. The 1994 Reform Act 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. Lending institutions regulated by federal agencies are prohibited from offering loans on properties located in a Special Flood Hazard Area (SFHA) of a community participating in the NFIP unless the property is covered by flood insurance.[16] The amount of flood insurance required by lending institutions must be at least equal to the outstanding principal balance of the loan, or the maximum amount available under the NFIP, whichever is less.

The Biggert-Waters Flood Insurance Reform Act

In 2012[17] the United States Congress passed the Biggert-Waters Flood Insurance Reform Act (Biggert-Waters Act). 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. 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.

2014 Federal Flood Reform Bills

The Consolidated Appropriations Act of 2014 and the Homeowner Flood Insurance Affordability Act of 2014 repealed or modified some provisions of the Biggert-Waters Act. The new law reduced the rate mandatory rate increases for subsidized properties from 25 percent annually to no less than 5 percent, generally not to increase more than 18 percent annually.[18] 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 percent 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 percent annual premium increase.

[14] 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).
[15] Office of Comptroller of Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, Farm Credit Administration and Federal Reserve.
[16] *FDIC Compliance Manual*, V – 6.1. http://www.fdic.gov/regulations/compliance/manual/index.html (Last accessed by staff on January 7, 2014).
[17] http://www.fema.gov/flood-insurance-reform-act-2012 (Last accessed by staff on January 2, 2014).
[18] Federal Emergency Management Agency, Homeowner Flood Insurance Affordability Act Overview (April 3, 2014). (Last accessed by staff on March 9, 2015).

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.

Flood Insurance in Florida

NFIP Flood Insurance in Florida

Over two million NFIP policies are written on Florida properties, with approximately 268,500 policies receiving subsidized rates.[19] This accounts for approximately 37 percent of the total policies written by the NFIP.

Historically, properties insured in Florida have paid approximately $3.60 in premium for NFIP flood coverage for every $1 received in claims payments.[20] 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, the property suffers severe, repeated flood losses, or 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.

Private Market Flood Insurance in Florida

The 2014 Legislature enacted CS/CS/CS/SB 542, governing the sale of personal lines, residential flood insurance. 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.

[19] Office of Insurance Regulation, *The Biggert-Waters Flood Insurance Reform Act of 2012*, (Presentation to the Florida Senate Banking and Insurance Committee on October 8, 2013). http://flsenate.gov/PublishedContent/Committees/2012-2014/BI/MeetingRecords/MeetingPacket_2346.pdf.

[20] Wharton Center for Risk Management and Decision Processes, *Who's Paying and Who's Benefiting Most From Flood Insurance Under the NFIP? A Financial Analysis of the U.S. National Flood Insurance Program (NFIP)*, (Issue Brief, Fall 2011).

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 bill 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.

III. Effect of Proposed Changes:

Section 1 amends s. 163.3178(2)(f), F.S., to require local governments when drafting their comprehensive coastal management plans to:

- Include development and redevelopment principles, strategies, and engineering solutions that reduce the flood risk in coastal areas which results from high-tide events, storm surge, flash floods, stormwater runoff, and the related impacts of sea-level rise.
- Encourage the use of best practices development and redevelopment principles, strategies, and engineering solutions that will result in the removal of coastal real property from flood zone designations established by the Federal Emergency Management Agency.
- Identify site development techniques and best practices that may reduce losses due to flooding and claims made under flood insurance policies issued in this state.

Section 2 creates s. 195.088, F.S., to require county property appraisers to submit elevation certificates to the Division of Emergency Management. The bill requires elevation certificates developed by FEMA to be completed by a licensed surveyor and mapper in accordance with the checklist adopted by DEM. A surveyor and mapper who completes an elevation certificate must, within 30 days of completion, submit a copy of the certificate to the property appraiser office in the county in which the property that was evaluated resides. The DEM must establish a schedule

that requires property appraisers to regularly submit copies of the elevation certificates they have received from licensed surveyors and mappers.

Section 3 amends s. 627.715, F.S., to revises the requirements for customized flood insurance by eliminating the requirement that such coverage be broader than standard or preferred flood coverage. Customized coverage instead is defined as coverage for the peril of flood that differs from standard or preferred coverage by:

- Being in an agreed upon amount between the insurer and policyholder.
- Including a deductible as authorized in s. 627.701, F.S.
- Being adjusted in accordance with s. 627.7011(3), F.S., or adjusted only on the basis of the actual cash value of the property.
- 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.

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 section clarifies that deductibles for flood coverage and flood insurance policy limits must be promptly noted on a policy's declarations page or face page.

The section requires all licensed insurance agents to quote a flood insurance policy when quoting an insurance policy for a residential structure located within a Special Flood Hazard Area designated by FEMA. If the property owner declines to obtain flood insurance coverage, the agent must maintain a record of that declination for 36 months. The bill also clarifies the signed acknowledgement that a licensed insurance agent must obtain notifying the applicant that discontinuing coverage from the National Flood Insurance Program (NFIP). The notice is revised to specify that it is policyholders who might lose subsidies are those who have subsidized NFIP policies.

Lastly, the section allows an insurer to request from the Office of Insurance Regulation 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. 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.

Section 4 the effective date of the bill is July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Policyholders will have greater flexibility when purchasing flood insurance.

C. Government Sector Impact:

Local governments must include flood risks within their coastal management plan. There could be added costs to local governments for the added development of the plan and its enforcement.

Local county property appraisers will be required to receive flood elevation certificates from licensed surveyors and mappers and must regularly submit the certificates to the Department of Emergency Management. The Department of Emergency Management must establish the schedule for which local county property appraisers are to regularly submit elevation certificates they have received. The added cost to the counties and department is unknown.

The Office of Insurance Regulations must establish a flood certification that is to be issued to companies that sell private flood insurance policies that are equal to or greater than the coverages in a policy sold by the National Flood Insurance Program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 163.3178, 627.715.

This bill creates section 195.088 of the Florida Statutes:

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Brandes

22-00259C-15 20151094__

A bill to be entitled

An act relating to the peril of flood; amending s. 163.3178, F.S.; specifying components that must be contained in the coastal management element required for a local government comprehensive plan; creating s. 195.088, F.S.; defining terms; requiring a licensed surveyor and mapper to complete an elevation certificate in accordance with a checklist developed by the Division of Emergency Management and to submit a copy of the elevation certificate to a specified property appraiser within a certain time after its completion; authorizing the redaction of certain personal information from the copy; requiring each property appraiser to submit the copies of elevation certificates to the division on a schedule established by the division; amending s. 627.715, F.S.; revising the required coverage for customized flood insurance; specifying how such coverage may differ from standard and preferred flood insurance; deleting a provision that prohibits supplemental flood insurance from including excess coverage over any other insurance covering the peril of flood; revising the information that must be prominently noted on a certain page of a flood insurance policy; requiring an agent to offer a flood insurance quote when quoting an insurance policy that will cover a residential structure located within a specified area; requiring the agent to maintain a record of an insured's declination of flood insurance coverage for a specified period of time; revising the

22-00259C-15 20151094__

notice that must be provided to and acknowledged by an applicant for flood coverage from an authorized or surplus lines insurer if the applicant's property is receiving flood insurance under the National Flood Insurance Program; allowing an authorized insurer to request a certification from the Office of Insurance Regulation which indicates that a policy, contract, or endorsement issued by the insurer provides coverage for the peril of flood which equals or exceeds the flood coverage offered by the National Flood Insurance Program; authorizing such insurer or its agent to reference or include the certification in specified advertising, communications, and documentation; providing an effective date.

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

Section 1. Paragraph (f) of subsection (2) of section 163.3178, Florida Statutes, is amended to read:

163.3178 Coastal management.—

(2) Each coastal management element required by s. 163.3177(6)(g) shall be based on studies, surveys, and data; be consistent with coastal resource plans prepared and adopted pursuant to general or special law; and contain:

(f) A redevelopment component <u>that</u> ~~which~~ outlines the principles <u>that must</u> ~~which shall~~ be used to eliminate inappropriate and unsafe development in the coastal areas when opportunities arise. <u>The component must:</u>

<u>1. Include development and redevelopment principles,</u>

strategies, and engineering solutions that reduce the flood risk in coastal areas which results from high-tide events, storm surge, flash floods, stormwater runoff, and the related impacts of sea-level rise.

2. Encourage the use of best practices development and redevelopment principles, strategies, and engineering solutions that will result in the removal of coastal real property from flood zone designations established by the Federal Emergency Management Agency.

3. Identify site development techniques and best practices that may reduce losses due to flooding and claims made under flood insurance policies issued in this state.

Section 2. Section 195.088, Florida Statutes, is created to read:

195.088 Property appraisers to submit elevation certificates to the Division of Emergency Management.—

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

(a) "Division" means the Division of Emergency Management established within the Executive Office of the Governor under s. 14.2016.

(b) "Elevation certificate" means the certificate used to demonstrate the elevation of property which has been developed by the Federal Emergency Management Agency pursuant to federal floodplain management regulation or which is completed by a licensed surveyor and mapper.

(c) "Licensed surveyor and mapper" has the same meaning as provided in s. 472.005 for "surveyor and mapper."

(2) An elevation certificate must be completed by a licensed surveyor and mapper in accordance with the checklist

developed by the division. Within 30 days after the completion of an elevation certificate, a licensed surveyor and mapper must submit a copy of the certificate to the property appraiser of the county in which the property that was surveyed or mapped is located. The copy must be unaltered, except that the licensed surveyor and mapper may redact the name of the property owner.

(3) Each property appraiser shall submit the copies received under subsection (2) to the division on a regular schedule established by the division.

Section 3. Section 627.715, Florida Statutes, is amended to read:

627.715 Flood insurance.—An authorized insurer may issue an insurance policy, contract, or endorsement providing personal lines residential coverage for the peril of flood on any structure or the contents of personal property contained therein, subject to this section. This section does not apply to commercial lines residential or commercial lines nonresidential coverage for the peril of flood. This section also does not apply to coverage for the peril of flood that is excess coverage over any other insurance covering the peril of flood. An insurer may issue flood insurance policies, contracts, or endorsements on a standard, preferred, customized, or supplemental basis.

(1)(a)1. Standard flood insurance must cover only losses from the peril of flood, as defined in paragraph (b), equivalent to that provided under a standard flood insurance policy under the National Flood Insurance Program. Standard flood insurance issued under this section must provide the same coverage, including deductibles and adjustment of losses, as that provided under a standard flood insurance policy under the National Flood

Insurance Program.

2. Preferred flood insurance must include the same coverage as standard flood insurance but:

a. Include, within the definition of "flood," losses from water intrusion originating from outside the structure that are not otherwise covered under the definition of "flood" provided in paragraph (b).

b. Include coverage for additional living expenses.

c. Require that any loss under personal property or contents coverage that is repaired or replaced be adjusted only on the basis of replacement costs up to the policy limits.

3. Customized flood insurance must provide ~~include~~ coverage for the peril of flood, and may differ from standard and preferred ~~that is broader than the coverage provided under standard~~ flood insurance by:

a. Including coverage that is broader than the coverage provided under standard flood insurance;

b. Being in an amount agreed upon by the insurer and insured, such as coverage that is limited to the total amount of each outstanding mortgage applicable to the covered property, if such coverage does not include a provision penalizing the policyholder for not insuring the covered property up to the replacement cost;

c. Including a deductible as authorized in s. 627.701;

d. Requiring that a loss to a dwelling be adjusted in accordance with s. 627.7011(3) or adjusted only on the basis of the actual cash value of the property;

e. Restricting flood coverage to the principal building, as defined in the applicable policy;

f. Including or excluding coverage for additional living expenses; and

g. Excluding coverage, as to the peril of flood, for personal property or contents.

4. Supplemental flood insurance may provide coverage designed to supplement a flood policy obtained from the National Flood Insurance Program or from an insurer issuing standard or preferred flood insurance pursuant to this section. Supplemental flood insurance may provide, but need not be limited to, coverage for jewelry, art, deductibles, and additional living expenses. ~~Supplemental flood insurance does not include coverage for the peril of flood that is excess coverage over any other insurance covering the peril of flood.~~

(b) "Flood" means 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, at least one of which is the policyholder's property, from:

1. Overflow of inland or tidal waters;

2. Unusual and rapid accumulation or runoff of surface waters from any source;

3. Mudflow; or

4. 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 in this paragraph.

(2) ~~Any limitations on~~ Flood coverage deductibles and ~~or~~ policy limits pursuant to this section~~, including, but not limited to, deductibles,~~ must be prominently noted on the policy

declarations page or face page.

(3)(a) An insurer may establish and use flood coverage rates in accordance with the rate standards provided in s. 627.062.

(b) For flood coverage rates filed with the office before October 1, 2019, the insurer may also establish and use such rates in accordance with the rates, rating schedules, or rating manuals filed by the insurer with the office which allow the insurer a reasonable rate of return on flood coverage written in this state. Flood coverage rates established pursuant to this paragraph are not subject to s. 627.062(2)(a) and (f). An insurer shall notify the office of any change to such rates within 30 days after the effective date of the change. The notice must include the name of the insurer and the average statewide percentage change in rates. Actuarial data with regard to such rates for flood coverage must be maintained by the insurer for 2 years after the effective date of such rate change and is subject to examination by the office. The office may require the insurer to incur the costs associated with an examination. Upon examination, the office, in accordance with generally accepted and reasonable actuarial techniques, shall consider the rate factors in s. 627.062(2)(b), (c), and (d), and the standards in s. 627.062(2)(e), to determine if the rate is excessive, inadequate, or unfairly discriminatory.

(4) A surplus lines agent may export a contract or endorsement providing flood coverage to an eligible surplus lines insurer without making a diligent effort to seek such coverage from three or more authorized insurers under s. 626.916(1)(a). This subsection expires July 1, 2017.

(5) In addition to any other applicable requirements, an insurer providing flood coverage in this state must:

(a) Notify the office at least 30 days before writing flood insurance in this state; and

(b) File a plan of operation and financial projections or revisions to such plan, as applicable, with the office.

(6) Citizens Property Insurance Corporation may not provide insurance for the peril of flood.

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

(8) An agent must:

(a) Offer a flood insurance quote when quoting an insurance policy that will cover a residential structure located within a Special Flood Hazard Area designated by the Federal Emergency Management Agency. If the insured declines to obtain flood insurance coverage, the agent must maintain a record of that declination for 36 months.

(b) Upon receiving ~~obtaining~~ an application for flood coverage from an authorized or surplus lines insurer for a property receiving flood insurance under the National Flood Insurance Program, ~~must~~ obtain an acknowledgment signed by the applicant before placing the coverage with the authorized or surplus lines insurer. The acknowledgment must notify the applicant that, if the applicant discontinues coverage under the National Flood Insurance Program which is provided at a subsidized rate, the full risk rate for flood insurance may apply to the property if the applicant ~~such insurance is~~ later

seeks to reinstate coverage ~~obtained~~ under the ~~National Flood Insurance~~ program.

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

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

(11) An authorized insurer offering flood insurance in this state may request a certification by the office which indicates that a policy, contract, or endorsement issued by the insurer under this section provides coverage for the peril of flood which equals or exceeds the flood coverage offered by the National Flood Insurance Program. The authorized insurer or its agent may reference or include the certification in advertising and communications with an agent, a lending institution, an insured, and a potential insured. The authorized insurer may include a statement that notifies an insured of the certification on the declarations page or other policy documentation related to flood coverage.

Section 4. This act shall take effect July 1, 2015.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 27, 2015

I respectfully request that **Senate Bill #1094**, relating to **Peril of Flood**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 22

File signed original with committee office

S-020 (03/2004)

634480

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Montford) recommended the following:

Senate Amendment (with title amendment)

Delete lines 23 - 71

and insert:

officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a property rate filing subject to paragraph (2)(a):

1. The signing officer and actuary have reviewed the rate

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filing;

2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading;

3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and

4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.

Section 2. Subsection (1) of section 627.0645, Florida Statutes, is amended to read:

627.0645 Annual filings.—

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

(a) Workers' compensation and employer's liability insurance; or

(b) ~~Commercial property and casualty~~ Insurance as defined in ss. 624.604 and 624.605, but limited to coverage of commercial risks ~~s. 627.0625(1)~~ other than commercial residential multiperil ~~multiple line and commercial motor vehicle~~,

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shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

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

And the title is amended as follows:

Delete lines 3 - 15

and insert:

procedures; amending s. 627.062, F.S.; restricting to certain property rate filings a requirement that the chief executive officer or chief financial officer and chief actuary of a property insurer certify the information contained in a rate filing; amending s. 627.0645, F.S.; exempting commercial nonresidential multiperil insurance from annual base rate filing; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 916
INTRODUCER:	Senator Montford
SUBJECT:	Commercial Insurer Rate Filing Procedures
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Pre-meeting**
2.			CM	
3.			RC	

I. Summary:

SB 916 amends certification requirements for certain types of commercial insurance. Current law requires the chief executive officer or chief financial officer and the chief actuary of a property insurer to certify, under oath, that they have reviewed a company rate filing and certify that it is accurate, that fairly represents the basis for the filing, reflects all premium savings reasonably expected to result from legislative enactments; and that it is compliant with generally accepted and reasonable actuarial techniques. This bill limits the certification requirements to residential property rate filings. Commercial property insurers, which generally do not make rate filings, will no longer have to complete certifications.

This bill revises the types of commercial property and casualty insurance for which annual base rate filings are not required by s. 627.0645, F.S. The bill exempts commercial multiperil insurance and commercial residential multiperil insurance from the annual base rate filing requirement and clarifies that commercial motor vehicle insurance is also exempt.

II. Present Situation:

Ratemaking Regulation for Property, Casualty, and Surety Insurance

The rating requirements for property, casualty, and surety insurance are located in part I of ch. 627, F.S., which is entitled the "Rating Law,"[1] and applies to property, casualty, and surety insurance.[2] Section 627.062(1), F.S., specifies that the rates for all classes to which part I applies "shall not be excessive, inadequate, or unfairly discriminatory."

Section 627.062(2)(a), F.S., describes the filing process and time frames that must be followed by all insurers subject to its provisions. Generally, insurers may choose to submit their rate to the

[1] *See* s. 627.011, F.S.
[2] *See* s. 627.021(1), F.S.

Office of Insurance Regulation ("OIR") pursuant to either the "file and use" method or the "use and file" method. Under "file and use," the insurer submits its proposed rate to the OIR at least 90 days before the rate's effective date but does not implement the rate until it is approved.[3] Under "use and file," the insurer may implement the rate before filing for approval, but must submit the filing within 30 days of the rate's effective date.[4] Under "use and file," if a portion of the rate is subsequently found to be excessive, the insurer must refund to policyholders the portion of the rate that is excessive.[5]

For those insurers that file under s. 627.062(2)(a), F.S., the OIR applies the following factors in determining whether a rate is excessive, inadequate, or unfairly discriminatory:

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

Types of Insurance Exempt from Filing and Review Requirements

The following types of insurance are exempt from the filing and review requirements of s. 627.062(2)(a), F.S.:

- Excess or umbrella.
- Surety and fidelity.
- Boiler and machinery and leakage and fire-extinguishing equipment.
- Errors and omissions.
- Directors and officers, employment practices and management liability.
- Intellectual property and patent infringement liability.
- Advertising injury and Internet liability.
- Property risks rated under a highly protected risks rating plan.
- General liability.
- Nonresidential property, except for collateral protection insurance as defined in s. 624.6085, F.S.
- Nonresidential multiperil.
- Excess property.

[3] *See* s. 627.062(2)(a)1., F.S.
[4] *See* s. 627.062(2)(a)2., F.S.
[5] *Id.*

- Burglary and theft.
- Certain types of medical malpractice insurance.
- Any other commercial lines categories of insurance or commercial lines risks that the OIR determines should not be subject to the filing and review requirements because of the existence of a competitive market for such insurance or to improve the general operational efficiency of the OIR.

These types of insurance coverages continue to be subject to s. 627.062(1), F.S., which requires that rates shall not be excessive, inadequate, or unfairly discriminatory.

Section 627.062(8)(a), F.S., requires the chief executive officer or chief financial officer and the chief actuary of a property insurer to certify, under oath, that they have reviewed a rate filing and that it:

- Is accurate;
- Fairly represents the basis for the filing;
- Reflects all premium savings reasonably expected to result from legislative enactments; and
- Is compliant with generally accepted and reasonable actuarial techniques.

The certification requirement applies to all property insurance even though rate filings are not required for all property insurance.

Section 627.0645, F.S., requires every insurer writing any line of property or casualty insurance, except workers' compensation, employer's liability and specified commercial property and casualty insurance, to make an annual base rate filing for each line of insurance written. If no rate change is proposed, the insurer may submit a certification from an actuary, in lieu of the base rate filing, which states that the existing rate is actuarially sound and is not inadequate.[6] The current exemption from the requirement to make an annual base rating does not cover all types of insurance that are exempt from rate filing and approval requirements.

Section 627.0651, F.S., provides the rate review process for motor vehicle insurance rates. The rate submission and review process is similar to the rating law in s. 627.062, F.S., for other property and casualty lines of insurance. Motor vehicle rate filings must be submitted to the OIR either by the "file and use" or "use and file" method.[7] Upon receiving notice of the rate filing, the OIR reviews the rate to determine if it is excessive, inadequate or unfairly discriminatory.[8] In reviewing a rate filing, the OIR may require the insurer to provide at the insurer's expense all information necessary to evaluate the condition of the company and the reasonableness of the rate filing.[9] Under s. 627.0651(14), F.S., commercial motor vehicle insurance is not subject to these requirements or the requirement to make an annual base rate filing under s. 627.0645, F.S., however, the latter statute indicates that commercial motor vehicle insurers do have to make the annual base rate filing, thus creating a statutory conflict.

[6] *See* s. 627.0645(3)(b), F.S.
[7] Section 627.0651(1), F.S.
[8] Section 627.0651(2), F.S.
[9] Section 627.0651(9), F.S.

III. Effect of Proposed Changes:

Section 1 of this bill amends s. 627.062(8)(a), F.S., to limit the certification requirements to residential property rate filings. Commercial property insurers, which generally do not make rate filings, will no longer have to complete certifications. This would have the effect of eliminating the certification requirement for collateral protection insurance.[10]

Section 2 of this bill revises the definitions of commercial property and casualty insurance for which annual base rate filings are not required by s. 627.0645, F.S. The bill also exempts commercial residential multiperil insurance, which is a type of insurance that is subject to rate review and approval. The section also clarifies that commercial motor vehicle insurers are not required to make an annual base rate filing.

Section 4 provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may result in a nominal reduction in costs to insurers.

C. Government Sector Impact:

According to an analysis provided by the OIR (on file with committee staff), this bill will have no fiscal impact on the OIR.

[10] Section 624.6085, F.S., defines "collateral protection insurance" as "commercial property insurance under which a creditor is the primary beneficiary and policyholder and which protects or covers an interest of the creditor arising out of a credit transaction secured by real or personal property. Initiation of such coverage is triggered by the mortgagor's failure to maintain insurance coverage as required by the mortgage or other lending document."

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.062 and 627.0645.

This bill reenacts section 627.0651 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Montford

3-00897A-15 2015916__

A bill to be entitled

An act relating to commercial insurer rate filing procedures; amending s. 627.062, F.S.; limiting to residential property insurers the requirement that property insurers certify certain information presented in rate filings as truthful, complete, and in compliance with specified actuarial techniques; amending s. 627.0645, F.S.; revising the types of commercial insurers that are exempt from making certain required annual base rate filings with the Office of Insurance Regulation; reenacting s. 627.0651(14)(a), F.S., relating to the making and use of rates for motor vehicle insurance, to incorporate the amendment made to s. 627.0645, F.S., in a reference thereto; providing an effective date.

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

Section 1. Paragraph (a) of subsection (8) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.—

(8)(a) The chief executive officer or chief financial officer of a residential property insurer and the chief actuary of a residential property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission, the following information, which must accompany a residential property rate filing:

1. The signing officer and actuary have reviewed the rate filing;

3-00897A-15 2015916__

2. Based on the signing officer's and actuary's knowledge, the rate filing does not contain any untrue statement of a material fact or omit ~~to state~~ a material fact necessary to make the statements ~~made~~, in light of the circumstances under which such statements were made, not misleading;

3. Based on the signing officer's and actuary's knowledge, the information and other factors described in paragraph (2)(b), including, but not limited to, investment income, fairly present in all material respects the basis of the rate filing for the periods presented in the filing; and

4. Based on the signing officer's and actuary's knowledge, the rate filing reflects all premium savings that are reasonably expected to result from legislative enactments and are in accordance with generally accepted and reasonable actuarial techniques.

Section 2. Subsection (1) of section 627.0645, Florida Statutes, is amended to read:

627.0645 Annual filings.—

(1) Each rating organization filing rates for, and each insurer writing, any line of property or casualty insurance to which this part applies, except:

(a) Workers' compensation and employer's liability insurance; or

(b) Commercial property insurance and commercial casualty insurance, which have the same meaning as the terms "property insurance" and "casualty insurance" as defined in ss. 624.604 and 624.605, respectively, but limited to coverage for commercial risks ~~s. 627.0625(1) other than commercial multiple line and commercial motor vehicle~~,

shall make an annual base rate filing for each such line with the office no later than 12 months after its previous base rate filing, demonstrating that its rates are not inadequate.

Section 3. For the purpose of incorporating the amendment made by this act to section 627.0645, Florida Statutes, in a reference thereto, paragraph (a) of subsection (14) of section 627.0651, Florida Statutes, is reenacted to read:

627.0651 Making and use of rates for motor vehicle insurance.—

(14)(a) Commercial motor vehicle insurance is not subject to subsection (1), subsection (2), or subsection (9) or s. 627.0645.

Section 4. This act shall take effect July 1, 2015.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Agriculture, *Chair*
Appropriations Subcommittee on Education, *Vice Chair*
Appropriations
Banking and Insurance
Education Pre-K - 12
Rules

SENATOR BILL MONTFORD
3rd District

March 2, 2015

Senator Lizbeth Benacquisto, Chair
Senate Banking & Insurance Committee
326 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Benacquisto:

I respectfully request that SB 916 be scheduled for a hearing before the Senate Banking & Insurance Committee. SB 916 would clarify types of commercial insurance not currently subject to OIR rate-filing procedures.

Your assistance and favorable consideration of my request is greatly appreciated.

Sincerely,

Bill Montford

William "Bill" Montford
State Senator, District 3

cc: James Knudson, Staff Director

BJM/mam

REPLY TO:
❒ 214 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5003
❒ 20 East Washington Street, Suite D, Quincy, Florida 32351 (850) 627-9100

Senate's Website: *www.flsenate.gov*

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 728
INTRODUCER:	Senator Benacquisto
SUBJECT:	Health Insurance Coverage for Opioids
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			HP	
3.			AP	

I. Summary:

SB 728 allows a health insurance policy providing coverage for opioid analgesic drug products to impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the policy imposes the same prior authorization requirement for opioid analgesic drug products *without* an abuse-deterrence labeling claim. The bill also prohibits a policy from requiring the use of an opioid analgesic *without* an abuse-deterrent labeling claim before providing coverage for an abuse-deterrent opioid analgesic drug product. Abuse deterrent formulations have characteristics that help prevent widespread abuse by impeding the delivery of their active ingredients, thereby reducing the potential for abuse, diversion, and misuse of the drug.

The abuse of prescription drugs in the United States has been described as an epidemic. Every day in the United States, 120 people die because of drug overdose, and another 6,748 are treated in emergency rooms for the misuse or abuse of drugs.[1] In 2010, 16,651 people in the United States died from a drug overdose involving opioid analgesics, such as oxycodone, hydrocodone, and methadone.

II. Present Situation:

Prescription opioid[2] analgesics are a critical component of pain management particularly for treating acute and chronic medical pain, providing humane hospice care for cancer patients, and

[1] Centers for Disease Control. Prescription Drug Overdose in the United States: Factsheet. http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html (accessed March 7, 2015).

[2] Medications that fall within this class include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin, Percocet), morphine (e.g., Kadian, Avinza), codeine, and related drugs. Hydrocodone products are the most commonly prescribed for a variety of painful conditions, including dental and injury-related pain. Morphine is often used before and after surgical procedures to alleviate severe pain. Codeine, on the other hand, is often prescribed for mild pain. See National Institute on

treating patients in drug treatment programs. When used properly, opioid analgesic drugs provide significant benefits for patients. However, abuse and misuse of these products has created a serious and growing public health problem. In the United States, approximately 4.5 million[3] individuals use prescription pain medications for nonmedical purposes,[4] resulting in more than 16,000 deaths[5] annually. Recent studies indicate that pharmaceuticals, especially opioid analgesics have driven the increase in drug overdose deaths.[6] In 2007, the total U.S. societal costs of prescription opioid abuse[7] was estimated at $55.7 billion.[8]

Food and Drug Administration Guidance on Abuse Deterrent Opioids

To reduce the misuse and abuse of prescription drugs, the Food and Drug Administration released draft guidance[9] to assist the pharmaceutical industry in developing new formulations of opioid drugs with abuse-deterrent properties. The goal of abuse-deterrence products is to limit access or attractiveness of the highly desired active ingredient for abusers while assuring the safe and effective release of the medication for patients. The document provides guidance about the studies that should be conducted to demonstrate that a given formulation has abuse-deterrent properties, how the studies will be evaluated, and what labeling clams may be approved based on the results of the studies.

According to the guidance, opioid analgesics can be abused in a number of ways. For example, they can be swallowed whole, crushed and swallowed, crushed and snorted, crushed and smoked, or crushed, dissolved and injected. Abuse-deterrent formulations should target known or expected routes of abuse for the opioid drug substance for that formulation. As a general framework, the FDA guidance provides that abuse-deterrent formulations are categorized in one of the following groups:

1. *Physical/Chemical barriers* – Physical barriers can prevent chewing, crushing, cutting, grating, or grinding. Chemical barriers can resist extraction of the opioid using common solvents like water, alcohol, or other organic solvents. Physical and chemical barriers can change the physical form of an oral drug rendering it less amenable to abuse.
2. *Agonist/Antagonist combinations* – An opioid antagonist can be added to interfere with, reduce, or defeat the euphoria associated with abuse. The antagonist can be sequestered and

Drug Abuse at http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/what-are-opioids (accessed March 7, 2015).

[3] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. September 4, 2014, The NSDUH Report: Substance and Use and Mental Health Estimates from the 2013 National Survey on Drug Use and health: Overview of Findings (available at http://store.samhsa.gov/shin/content/NSDUH14-094.pdf) (accessed February 20, 2015).

[4] Nonmedical use is defined as the use of prescription-type drugs that were not prescribed for the respondent or use only for the experience or feeling they caused. Nonmedical use of any prescription type drug does not include over-the-counter drugs.

[5] Centers for Disease Control and Prevention, Prescription Drug Overdose in the United States: Factsheet. February 9, 2015. Available at: http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html.

[6] Christopher Jones, et al., Pharmaceutical Overdose, United States, 2010, *Journal of American Medical Association*. 2013;309:657.

[7] Birnbaum, H.G., et al., Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States. Pain *Medicine*. 12:657-667.

[8] The breakout of this estimate is workplace costs $25.6 billion (46 percent), health care costs $25 billion (45 percent), and criminal justice costs $5.1 billion (9 percent). (USD in 2009).

[9] U.S. Food and Drug Administration, Draft Guidance for Industry: Abuse-Deterrent Opioids-Evaluation and Labeling, January 2013.

released only upon manipulation of the product. For example, a drug product may be formulated such that the substance that acts as an antagonist is not clinically active when the product is swallowed but becomes active if the product is crushed and injected or snorted.
3. *Aversion* – Substances can be combined to produce an unpleasant effect if the dosage form is manipulated prior to ingestion or a higher dosage than directed is used.
4. *Delivery System* (including depot injectable formulations and implants) – Certain drug release designs or the method of drug delivery can offer resistance to abuse. For example, a sustained-release depot injectable formulation that is administered intramuscularly or a subcutaneous implant can be more difficult to manipulate.
5. *Prodrug* – A prodrug that lacks opioid activity until transformed in the gastrointestinal tract can be unattractive for intravenous injection or intranasal routes of abuse.
6. *Combination* – Two or more of the above methods can be combined to deter abuse.

The guidance provides that it is critical that labeling claims regarding abuse-deterrent properties be based on robust, compelling, and accurate data and analysis, and that any characterization of a product's abuse-deterrent properties or potential to reduce abuse be clearly and fairly communicated. Labeling language regarding abuse deterrence should describe the product's specific abuse-deterrent properties as well as the specific routes of abuse that the product has been developed to deter. The FDA provides that there are four general tiers of label claims available to describe the potential abuse-deterrent properties of a product:

- Tier 1: Product is formulated with physiochemical barriers to abuse.
- Tier 2: Product is expected to reduce or block effect of the opioid when it is manipulated.
- Tier 3: Product is expected to reduce abuse.
- Tier 4: Product has demonstrated reduced abuse in the community.

The FDA has approved four extended release opioids with abuse deterrent labels, indicating that they are expected to result in meaningful reductions in abuse.[10] There are approximately twelve products in development.

The increasing use of abuse deterrent is expected to reduce overall medical costs. One study[11] estimated the potential cost savings from introducing abuse-deterrent opioids may be in the range of $0.6 billion to 1.6 billion per year in the United States. The study notes that cost data was extrapolated from claims data of privately-insured national employers. The study also states that privately insured population accounts for approximately 60 percent of the U.S. population, and the costs and abuse patterns for Medicaid, uninsured individuals, and small employers could be different.

Regulation of Insurers and Health Maintenance Organizations

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities.[12] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of

[10] These include Reformulated OxyContin, Embeda, Hysingla, and Targiniq.
[11] Birnbaum HG, White, AG, et al. Development of a Budget-Impact Model to Quantify Potential Cost Savings from Prescription Opioids Designed to Deter Abuse or Ease of Extraction. Appl Health Econ Health Policy. 2009; 7(1); 61-70.
[12] Section 20.121(3)(a)1., F.S.

ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency pursuant to part III of ch. 641, F.S.[13]

Cost Containment Measures Used by Insurers and HMOs

Insurers use many cost containment strategies to manage medical and drug spending and utilization. For example, plans may place utilization management requirements on the use of certain drugs on their formulary, such as requiring enrollees to obtain prior authorization from their plan before being able to fill a prescription, requiring enrollees to first try a preferred drug to treat a medical condition before being able to obtain an alternate drug for that condition, or limiting the quantity of drugs that they cover over a certain period of time.

Under prior authorization, a health care provider is required to seek approval from an insurer before a patient may receive a specified diagnostic or therapeutic treatment or specified prescription drugs under the plan. A preferred drug list (PDL) is an established list of one or more prescription drugs within a therapeutic class deemed clinically equivalent and cost effective. In order to obtain another drug within the therapeutic class, not part of the PDL, prior authorization is required. Prior authorization for emergency services is not required. Preauthorization for hospital inpatient services is generally required.

In some cases, plans require an insured to try one drug first to treat his or her medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, a plan may require doctors to prescribe Drug A first. If Drug A does not work for a beneficiary, then the plan will cover Drug B. Advocates of step therapy state that a step therapy approach requires the use of clinically recognized first-line drug before approval of a more complex and often more expensive medication where the safety, effectiveness, and values has been well established before a second-line drug is authorized.

According to a published report by researchers affiliated with the National Institutes of Health, there is mixed evidence on the impact of step therapy policies.[14] A review of the literature by Brenda Motheral found that there is little good empirical evidence,[15] but other studies[16] suggest that step therapy policies have been effective at reducing drug costs without increasing the use of other medical services. However, some studies have found that the policies can increase total utilization costs over the long run because of increased inpatient admissions and emergency department visits.[17] One-step therapy policy for a typical antipsychotic medication in a Medicaid program was associated with a higher rate of discontinuity in medication use, an outcome that was linked to increased risk for hospitalization.[18]

[13] Section 641.21(1), F.S.
[14] The Ethics Of "Fail First": Guidelines and Practical Scenarios for Step Therapy Coverage Policies, Rahul K. Nayak and Steven D. Pearson *Health Affairs* 33, No.10 (2014):1779-1785.
[15] Pharmaceutical Step Therapy Interventions: A Critical Review of the Literature, Brenda R. Motheral, *Journal of Managed Care Pharmacy* 17, no. 2 (2011) 143-55.
[16] See fn. 11 at pg. 1780.
[17] See *id*.
[18] See *id*.

III. Effect of Proposed Changes:

Section 1 creates s. 627.64194, F.S., which provides requirements for opioid analgesic drug coverage. The terms, "abuse-deterrent opioid analgesic drug product" and "opioid analgesic drug product" are defined. An "abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the U.S. Food and Drug Administration with an abuse-deterrence labeling claim that indicates the drug product is expected to deter abuse. The term, "opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions in immediate-release, extended release, or long-acting form regardless of whether or not combined with other drug substances to form a single drug product or dosage form.

The bill would allow a health insurance policy that provides coverage for opioid analgesic drug products to impose a prior authorization for an abuse-deterrent opioid analgesic drug product only if the policy imposes the same prior authorization requirement for opioid analgesic drug products *without* an abuse-deterrence labeling claim. The bill also prohibits a policy from requiring the use of an opioid analgesic *without* an abuse-deterrent labeling claim before providing coverage for an abuse-deterrent opioid analgesic drug product. Abuse deterrent formulations have characteristics that help prevent widespread abuse by impeding the delivery of their active ingredients thereby reducing the potential for abuse and misuse of the drug.

Section 2 provides the bill takes effect July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Indeterminate.

The bill will provide patients with greater access to abuse-deterrent opioid analgesic drug products, which is expected to reduce opioid drug misuse, abuse, and diversion. The

increased use of abuse deterrent drugs is expected to reduce emergency room and drug treatment costs associated with the misuse or abuse of opioids without such abuse deterrent formulations.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 627.64194 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Benacquisto

30-00639C-15 2015728__

A bill to be entitled

An act relating to health insurance coverage for opioids; creating s. 627.64194, F.S.; defining terms; providing that a health insurance policy that covers opioid analgesic drug products may impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the insurer imposes the same requirement for each opioid analgesic drug product without an abuse-deterrence labeling claim; prohibiting such health insurance policy from requiring use of an opioid analgesic drug product without an abuse-deterrence labeling claim before providing coverage for an abuse-deterrent opioid analgesic drug product; providing an effective date.

WHEREAS, the Legislature finds that the abuse of opioids is a serious problem that affects the health, social, and economic welfare of this state, and

WHEREAS, the Legislature finds that an estimated 2.1 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers in 2012, and

WHEREAS, the Legislature finds that the number of unintentional overdose deaths from prescription pain relievers has more than quadrupled since 1999, and

WHEREAS, the Legislature is convinced that it is imperative for people suffering from pain to obtain the relief they need while minimizing the potential for negative consequences, NOW, THEREFORE,

30-00639C-15 2015728__

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

Section 1. Section 627.64194, Florida Statutes, is created to read:

627.64194 Requirements for opioid coverage.—

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

(a) "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the United States Food and Drug Administration with an abuse-deterrence labeling claim that indicates the drug product is expected to deter abuse.

(b) "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions in immediate-release, extended-release, or long-acting form regardless of whether or not combined with other drug substances to form a single drug product or dosage form.

(2) COVERAGE REQUIREMENTS.—A health insurance policy that provides coverage for opioid analgesic drug products:

(a) May impose a prior authorization requirement for an abuse-deterrent opioid analgesic drug product only if the policy imposes the same prior authorization requirement for each opioid analgesic drug product without an abuse-deterrence labeling claim which is covered by the policy.

(b) May not require use of an opioid analgesic drug product without an abuse-deterrence labeling claim before providing coverage for an abuse-deterrent opioid analgesic drug product.

Section 2. This act shall take effect July 1, 2015.

430690

LEGISLATIVE ACTION

Senate . House

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The Committee on Banking and Insurance (Benacquisto) recommended the following:

Senate Amendment (with title amendment)

Delete lines 145 - 155

and insert:

b. Any major structure, as defined in s. 161.54(6)(a), which is newly constructed or rebuilt, repaired, restored, or remodeled to increase the total square footage of finished area by more than 25 percent pursuant to ~~for which~~ a permit ~~is~~ applied for ~~on or~~ after July 1, 2015, ~~for new construction or substantial improvement as defined in s. 161.54(12)~~ is not

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eligible for coverage by the corporation if the structure is seaward of the coastal construction control line established pursuant to s. 161.053 or is within the Coastal Barrier Resources System as designated by 16 U.S.C. ss. 3501-3510.

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

And the title is amended as follows:

Delete lines 4 - 11

and insert:

627.351, F.S.; deleting a provision prohibiting certain improvements to major structures from being eligible for coverage by the Citizens Property Insurance Corporation; prohibiting coverage for major structures rebuilt, repaired, restored, or remodeled to increase the total square footage of finished area by a specified amount; reenacting s. 627.712(1), F.S., relating to residential windstorm coverage, to incorporate the amendment made by

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 842
INTRODUCER:	Senator Benacquisto
SUBJECT:	Citizens Property Insurance Corporation Eligibility for Coverage
DATE:	March 9, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Pre-meeting**
2.			CA	
3.			FP	

I. Summary:

SB 842 revises current law which makes it ineligible for Citizens Property Insurance Corporation (Citizens) coverage structures located seaward of the Coastal Construction Control Line or within a Coastal Barrier Resources System for which, after July, 1, 2015, a permit application is made for new construction or substantial improvement of the structure. The bill allows Citizens to provide coverage on structures built before July 1, 2015, and remodeled or rebuilt after July 1, 2015, to a size less than 125 percent of the original building's square footage.

II. Present Situation:

Citizens Property Insurance Corporation (Citizens)

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market.[1] Citizens is not a private insurance company.[2] Citizens was statutorily created in 2002 when the Florida Legislature combined the state's two insurers of last resort, the Florida Residential Property and Casualty Joint Underwriting Association (RPCJUA) and the Florida Windstorm Underwriting Association (FWUA). Citizens operates in accordance with the provisions in s. 627.351(6), F.S., and is governed by an eight member Board of Governors[3] (board) that administers its Plan of Operations, which is reviewed and approved by the Financial Services Commission. The Governor, President of the Senate, Speaker of the House of Representatives, and Chief Financial Officer each appoints two members to the board. Citizens is subject to regulation by the Florida Office of Insurance Regulation.

[1] Admitted market means insurance companies licensed to transact insurance in Florida.
[2] s. 627.351(6)(a)1., F.S. Citizens is also subject to regulation by the Office of Insurance Regulation.
[3] The Governor, the Chief Financial Officer, the President of the Senate and the Speaker of the House of Representatives.

Citizens offers property insurance in three separate accounts. Each account is a separate statutory account with separate calculations of surplus and deficits.[4] Assets may not be commingled or used to fund losses in another account.[5]

The Personal Lines Account (PLA) offers personal lines residential policies that provide comprehensive, multiperil coverage statewide, except for those areas contained in the Coastal Account. The PLA also writes policies that exclude coverage for wind in areas contained within the Coastal Account. Personal lines residential coverage consists of the types of coverage provided by homeowners, mobile homeowners, dwellings, tenants, and condominium unit owner's policies.

The Commercial Lines Account (CLA) offers commercial lines residential and nonresidential policies that provide basic perils coverage statewide, except for those areas contained in the Coastal Account. The CLA also writes policies that exclude coverage for wind in areas contained within the Coastal Account. Commercial lines coverage includes commercial residential policies covering condominium associations, homeowners' associations, and apartment buildings. The coverage also includes commercial nonresidential policies covering business properties.

The Coastal Account offers personal residential, commercial residential and commercial non-residential policies in coastal areas of the state. Citizens must offer policies that solely cover the peril of wind (wind only policies) and may offer multiperil policies.[6]

Eligibility for Insurance in Citizens

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

Eligibility Based on Premium Amount

Under current law, an applicant for residential insurance cannot buy insurance in Citizens if an admitted insurer in the private market offers the applicant insurance for a premium that does not exceed the Citizens premium by 15 percent or more. [7] In addition, the coverage offered by the private insurer must be comparable to Citizens' coverage.

[4] The Personal Lines Account and the Commercial Lines account are combined for credit and Florida Hurricane Catastrophe Fund coverage.
[5] s. 627.351(6)(b)2b., F.S.
[6] In August of 2007, Citizens began offering personal and commercial residential multiperil policies in this limited eligibility area. Additionally, near the end of 2008, Citizens began offering commercial non-residential multiperil policies in this account.
[7] s. 627.351(6)(c)5., F.S.

Under current law, a residential policyholder cannot renew insurance in Citizens if an insurer in the private market offers to insure the property at a premium equal to or less than the Citizens' renewal premium. The insurance from the private market insurer must be comparable to the insurance from Citizens in order for the renewal premium eligibility requirement to apply.[8]

Eligibility Based on Value of Property Insured

In addition to the eligibility restrictions based on premium amount, current law provides eligibility restrictions for homes and condominium units based on the value of the property insured.[9] Structures with a dwelling replacement cost or a condominium unit that has a dwelling and contents replacement cost of:

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

However, Citizens is allowed to insure structures with a dwelling replacement cost or a condominium unit with a dwelling and contents replacement cost of $1 million or less in Miami-Dade and Monroe counties, after the OIR determined these counties to be non-competitive.

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

Eligibility Based on Location of Property

Current law also provides an eligibility restriction for insurance in Citizens based on the location of the property. Major structures for which a building permit for new construction or a substantial improvement of the structure is applied for on or after July 1, 2015, and which are located seaward of the coastal construction control line (CCCL) or within the Coastal Barrier Resources System (CBRS) are ineligible for insurance in Citizens. The definition of "major structure" in s. 161.54, F.S., applies to Citizens' eligibility and is very broad, encompassing all residential and commercial buildings including houses, mobile homes, apartment buildings, condominiums, hotels, motels, and restaurants. The definition of "substantial improvement" in s. 161.54, F.S., applies to Citizens' eligibility. Generally, this definition makes any repair,

[8] s. 627.351(6)(c)5., F.S.
[9] s. 627.351(6)(a)3., F.S.

reconstruction, rehabilitation, or improvement to a structure that costs 50 percent or more of the market value of the structure a "substantial improvement." The statutory definition contains additional parameters and guidance and exclusions.

Coastal Construction Control Line (CCCL)

The Coastal Construction Control Line (CCCL) establishes an area of jurisdiction in which special siting and design criteria are applied to construction and related activities along the coast. Due to the potential environmental impacts and greater risk of hazards from wind and flood, the standards for construction within the CCCL are often more stringent than those applied in the rest of the state. Chapter 62B-33, Florida Administrative Code (F.A.C.), provides the design and siting requirements for obtaining a coastal construction control line permit. Approval or denial of a permit application is based upon a review of the siting or location of structures relative their proximity to the beach and the potential impacts to the beach dune system, adjacent properties, native salt resistant vegetation, and marine turtles. While most permit requests are approved as submitted, some are modified during the permitting process. The CCCL starts on the northeast coast of Florida near Fernandina Beach and runs south along the coast, ending approximately at Key Biscayne. On the west coast it extends from Crystal Beach in Pinellas County south along the coast to Marco Island in Collier County. There are very small pockets on CCCL areas north of Pinellas County until you reach the western border of Wakulla County. The CCCL then begins again in Franklin County in the panhandle and extends west to the Florida and Alabama border on the coast near Perdido Bay.

Coastal Barrier Resources System (CBRS)

Coastal Barrier Resources Act (CBRA) was passed by Congress in 1982. CBRA restricted federal spending and financial assistance in an effort to discourage development within a Coastal Barrier Resources System (CBRS). CBRS are designated barrier areas that protect the inland. While CBRA does not prohibit privately financed development, it does prohibit new federal financial assistance, including the purchasing of federal flood insurance from FEMA. In 1990, Congress passed the Coastal Barrier Improvement Act (CBIA). The CBIA tripled the size of the Coastal Barrier Resources System but allowed buildings constructed before 1982 to be covered by the federal flood insurance program. The CBRS consists of many of the coastal barriers in the state, including the entirety of the Florida Keys. There are 128 designated coastal barriers within Florida.

III. Effect of Proposed Changes:

SB 842 revises current law which makes it ineligible for Citizens Property Insurance Corporation (Citizens) coverage structures located seaward of the Coastal Construction Control Line or within a Coastal Barrier Resources System for which, after July, 1, 2015, a permit application is made for new construction or substantial improvement of the structure. The bill allows Citizens Property Insurance Corporation to provide coverage on structures permitted built before July 1, 2015, located seaward of the Coastal Construction Control Line or within a Coastal Barrier Resources System, and remodeled or rebuilt after July 1, 2015, to a size less than 125 percent of the original building's square footage.

The effective date of the bill is July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Property owners in the Florida Keys and other areas along the coast, who rebuild or remodel structures seaward of the CCCL or within a CBRS can remain eligible for coverage by Citizens Property Insurance Corporation as long as the structure is rebuilt or remodeled to a size less than 125 percent of the original buildings square footage. This will prevent certain circumstances where an insured is unable to obtain coverage for their property, particularly in coastal areas for which Citizens may be the only option for obtaining insurance. Under current law, a Citizens policyholder in these areas could incur major loss, rebuild their home to the same size, and would be ineligible for Citizens.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends s. 627.351 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Benacquisto

30-01118A-15 2015842__

A bill to be entitled

An act relating to Citizens Property Insurance Corporation eligibility for coverage; amending s. 627.351, F.S.; removing the prohibition against permits for substantial improvements from being eligible for coverage; authorizing coverage for major structures built before a certain date and subsequently rebuilt, repaired, restored, or remodeled to a specified percentage less than the major structure's original square footage; reenacting s. 627.712(1), F.S., to incorporate the amendment made by this act to s. 627.351, F.S.; providing an effective date.

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

Section 1. Paragraph (a) of subsection (6) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

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

1. The Legislature finds that private insurers are unwilling or unable to provide affordable property insurance coverage in this state to the extent sought and needed. The absence of affordable property insurance threatens the public health, safety, and welfare and likewise threatens the economic health of the state. The state therefore has a compelling public

30-01118A-15 2015842__

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

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

3. With respect to coverage for personal lines residential structures:

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

shall approve the method used by the corporation for valuing the dwelling replacement cost for the purposes of this subparagraph. If a policyholder is insured by the corporation before being determined to be ineligible pursuant to this subparagraph and such policyholder files a lawsuit challenging the determination, the policyholder may remain insured by the corporation until the conclusion of the litigation.

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

c. Effective January 1, 2016, a structure that has a dwelling replacement cost of $800,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $800,000 or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2015, may continue to be covered by the corporation until the end of the policy term.

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

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

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

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

b. Any major structure as defined in s. 161.54(6)(a) for

which a permit is applied on or after July 1, 2015, for new construction ~~or substantial improvement as defined in s. 161.54(12)~~ is not eligible for coverage by the corporation if the structure is seaward of the coastal construction control line established pursuant to s. 161.053 or is within the Coastal Barrier Resources System as designated by 16 U.S.C. ss. 3501-3510. This sub-subparagraph does not apply to any major structure built before July 1, 2015, and subsequently rebuilt, repaired, restored, or remodeled to a size less than 125 percent of the major structure's original square footage.

6. With respect to wind-only coverage for commercial lines residential condominiums, effective July 1, 2014, a condominium shall be deemed ineligible for coverage if 50 percent or more of the units are rented more than eight times in a calendar year for a rental agreement period of less than 30 days.

Section 2. For the purpose of incorporating the amendment made by this act to section 627.351, Florida Statutes, in a reference thereto, subsection (1) of section 627.712, Florida Statutes, is reenacted to read:

627.712 Residential windstorm coverage required; availability of exclusions for windstorm or contents.—

(1) An insurer issuing a residential property insurance policy must provide windstorm coverage. Except as provided in paragraph (2)(c), this section does not apply to risks that are eligible for wind-only coverage from Citizens Property Insurance Corporation under s. 627.351(6), and risks that are not eligible for coverage from Citizens Property Insurance Corporation under s. 627.351(6)(a)3. or 5. A risk ineligible for coverage by the corporation under s. 627.351(6)(a)3. or 5. is exempt from this

section only if the risk is located within the boundaries of the coastal account of the corporation.

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

594738

LEGISLATIVE ACTION

Senate . House

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The Committee on Banking and Insurance (Simmons) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (19) is added to section 120.80, Florida Statutes, to read:

120.80 Exceptions and special requirements; agencies.—

(19) DEPARTMENT OF FINANCIAL SERVICES.—Section 120.541(3) does not apply to the adoption of maximum reimbursement allowances and manuals approved by a three-member panel pursuant

to s. 440.13(12).

Section 2. This act shall take effect July 1, 2015.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to legislative ratification; amending s. 120.80, F.S.; providing that the maximum reimbursement allowances and manuals approved by a three-member panel for purposes of the Workers' Compensation Law are exempt from legislative ratification under the Administrative Procedure Act if the adverse impact or regulatory costs of such allowances or manuals exceed specified criteria; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1060
INTRODUCER:	Senator Simmons
SUBJECT:	Maximum Reimbursement Allowances
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			FP	

I. Summary:

SB 1060 exempts the uniform schedules of maximum reimbursement allowances for workers' compensation medical treatment and care adopted by the Three Member Panel (panel) from rule ratification by the Legislature. The panel adopts uniform schedules of maximum reimbursement allowances for medically-necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The Division of Workers' Compensation (division) of the Department of Financial Services undertakes administrative rulemaking in order to adopt each manual containing the uniform schedules of maximum reimbursement allowances established by the panel.

Pursuant to ch. 120, F.S., an agency begins the formal rulemaking process by filing a notice of the proposed rule, which is published in the Florida Administrative Register and must provide certain information, including the text of the proposed rule and a summary of the agency's statement of estimated regulatory costs (SERC) if one is prepared. 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.

The economic analysis, mandated for each SERC, must analyze a rule's potential impact over the 5-year period after the rule goes into effect. First discussed in the analysis is the rule's likely adverse impact on economic growth, private-sector job creation or employment, or private-sector investment. Next is the likely adverse impact on business competitiveness, productivity, or innovation. Finally, the analysis must discuss whether the rule is likely to increase regulatory costs, including any transactional costs. If the analysis projects the impact of the proposed rule in any one of these areas will exceed $1 million in the aggregate for the 5-year period, the rule cannot go into effect until ratified by the Legislature.

II. Present Situation:

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.[1] Rulemaking authority is delegated by the Legislature[2] through statute and authorizes an agency to "adopt, develop, establish, or otherwise create"[3] a rule. Agencies do not have discretion as to whether to engage in rulemaking.[4] To adopt a rule an agency must have a general grant of authority to implement a specific law by rulemaking.[5] The grant of rulemaking authority itself need not be detailed.[6] 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.[7]

An agency begins the formal rulemaking process by filing a notice of the proposed rule,[8] which is published by the Department of State in the Florida Administrative Register.[9] The notice must provide certain information, including the text of the proposed rule, and a summary of the agency's statement of estimated regulatory costs (SERC) if one is prepared. 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.[10]

The economic analysis, mandated for each SERC, must analyze a rule's potential impact over the 5-year period after the rule goes into effect. First discussed in the analysis is the rule's likely adverse impact on economic growth, private-sector job creation or employment, or private-sector investment.[11] Next is the likely adverse impact on business competitiveness,[12] productivity, or innovation.[13] Finally, the analysis must discuss whether the rule is likely to increase regulatory costs, including any transactional costs.[14] If the analysis shows the projected impact of the proposed rule in any one of these areas will exceed $1 million in the aggregate for the 5-year period, the rule cannot go into effect until ratified by the Legislature.[15]

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[1] Section 120.52(16), F.S.; *Florida Department of Financial Services v. Capital Collateral Regional Counsel-Middle Region*, 969 So.2d 527, 530 (Fla. 1st DCA 2007).
[2] *Southwest Florida Water Management District v. Save the Manatee Club, Inc.,* 773 So.2d 594 (Fla. 1st DCA 2000).
[3] Section 120.52(17), F.S.
[4] Section 120.54(1)(a), F.S.
[5] Sections 120.52(8) & 120.536(1), F.S.
[6] *Save the Manatee Club, Inc.*, supra at 599.
[7] *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).
[8] Section 120.54(3)(a)1, F.S.
[9] Section 120.55(1)(b)2, F.S.
[10] Section 120.541(2)(a), F.S.
[11] Section 120.541(2)(a)1., F.S.
[12] This factor includes the ability of those doing business in Florida to compete with those doing business in other states or domestic markets.
[13] Section 120.541(2)(a) 2., F.S.
[14] Section 120.541(2)(a) 3., F.S.
[15] Section 120.541(3), F.S.

Current law distinguishes between a rule being "adopted" and becoming enforceable or "effective."[16] A rule must be filed for adoption before it may go into effect[17] and cannot be filed for adoption until completion of the rulemaking process.[18] A rule submitted under s. 120.541(3), F.S., becomes effective if ratified by the Legislature, thus a rule must be filed for adoption before being submitted for legislative ratification.

Workers' Compensation Medical Benefits

For work-related injuries sustained by employees, workers' compensation provides medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, including medicines, medical supplies, durable medical equipment, and prosthetics.[19] The Division of Workers' Compensation of the Department of Financial Services administers the regulation of the workers' compensation system pursuant to ch. 440, F.S. The division administers and regulates many aspects of the health care delivery system, but does not establish the reimbursement formulas and methodologies for the compensation of providers and facilities that deliver medical services.

Schedules of Maximum Reimbursement Allowances

The Three-Member Panel (panel) is required to determine and adopt schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program must be reimbursed either by the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.[20]

The Three-Member Panel (panel) consists of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members appointed by the Governor, subject to confirmation by the Senate.[21] One member appointed by the Governor is a representative of employers and the other Governor's appointee is a representative of employees.

The Division of Workers' Compensation (division) of the Department of Financial Services presents recommendations to the panel on reimbursement and policy changes to the Health Care Provider Reimbursement Manual, Hospital Reimbursement Manual, and the Ambulatory Surgical Center Reimbursement Manual. The panel receives public comment on the proposed changes and either adopts the recommendations, amends the recommendations, or does not accept them. The panel's recommendations are implemented within each respective reimbursement manual.

[16] Section 120.54(3)(e)6, F.S. 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.
[17] Section 120.54(3)(e)6, F.S.
[18] Section 120.54(3)(e), F.S.
[19] Section 440.13(2)(a), F.S.
[20] Section 440.13(12), F.S.
[21] Section 440.13(12)(a), F.S.

The division undertakes rulemaking pursuant to ch. 120, F.S., in order to adopt each manual. The division includes the uniform schedules of maximum reimbursement allowances established by the panel in these rules. The division publishes the uniform schedules of maximum reimbursement allowances within the reimbursement manuals incorporated by reference into the rules. The division has taken the position that the rules incorporating the reimbursement manuals are subject to legislative ratification despite the statutory authority given to the Three-Member Panel to determine maximum reimbursement allowances and despite the explicit provisions that dictate the amount of reimbursement payable to various health care providers contained in s. 440.13(12), F.S.[22]

The division has adopted rules, as described below, providing for the maximum reimbursement allowances of health care providers, hospitals, and ambulatory surgical centers.

Health Care Providers. This manual[23] provides reimbursement policies and a schedule of maximum reimbursement allowances (MRA), for licensed physicians, licensed health care providers, licensed pharmacists and medical suppliers rendering medical services and supplies to Florida's injured workers.

Hospitals. This manual[24] contains the MRAs and establishes policy, procedures, principles and standards for implementing statutory provisions regarding reimbursement for medically necessary services and supplies provided to injured workers in a hospital setting.

Ambulatory Surgical Centers. This manual[25] contains the MRAs for surgical procedures performed in an ambulatory surgical center setting and defines a payment method for surgical and non-surgical services not defined in the fee schedule.

In 2015, the panel recommended that the reimbursement manuals should be exempt from the legislative ratification requirements of ch. 120, F.S.[26] The panel asserts that s. 440.13(12), F.S., already provides statutory authority to the panel to establish maximum reimbursement allowances and contains specific provisions on reimbursement amounts that are payable to health care providers.

Rule ratification can result in delays in the implementation of revised fee schedules. Delays in the adoption of fee schedules can result in the schedules becoming outdated and not representative of the marketplace. According to the division, requests for rule ratifications of the Health Care Provider Reimbursement Manual were submitted to the Legislature in 2012, 2013, and 2014. In 2013, legislation[27] was filed to ratify the manual; however, it failed to become law.[28]

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[22] Department of Financial Services Analysis of Senate Bill 1060 (March 5, 2015) (on file with Banking and Insurance Committee).
[23] Rule 69L-7.020, F.A.C.
[24] Rule 69L-7.501, F.A.C.
[25] Rule 69L-7.100, F.A.C.
[26] Three-Member Panel Biennial Report, 2015 Edition.
[27] HB 1165.
[28] Department of Financial Services Analysis of Senate Bill 1060 (March 5, 2015) (on file with Banking and Insurance Committee).

III. Effect of Proposed Changes:

Section 1 amends s. 120.541, F.S., by exempting the adoption of the maximum reimbursement manuals approved by the Three-Member Panel pursuant to s. 440.13(12), F.S., from rule ratification by the Legislature.

Section 2 reenacts s. 440.13(12), F.S.

Section 3 provides the bill will take effect July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

If the fee schedules are exempt from rule ratification, the manuals can be adopted in a timelier manner, resulting in fees schedules for providers being representative of the market place.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 120.541, 440.13.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Simmons

10-00885-15 20151060__

A bill to be entitled

An act relating to maximum reimbursement allowances; amending s. 120.541, F.S.; providing that a specified restriction does not apply to the adoption of maximum reimbursement allowances approved by the three-member panel; reenacting s. 440.13(12), F.S., to incorporate the amendment made to s. 120.541, F.S., in a reference thereto; providing an effective date.

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

Section 1. Subsection (3) of section 120.541, Florida Statutes, is amended to read:

120.541 Statement of estimated regulatory costs.—

(3) If the adverse impact or regulatory costs of the rule exceed any of the criteria established in paragraph (2)(a), the rule shall be submitted to the President of the Senate and 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. <u>This subsection does not apply to the adoption of maximum reimbursement allowances approved by the three-member panel pursuant to s. 440.13(12).</u>

Section 2. Subsection (12) of s. 440.13, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 120.541, Florida Statutes, in a reference thereto.

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

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: March 3, 2015

I respectfully request that **Senate Bill 1060**, relating to Maximum Reimbursement Allowances, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator David Simmons
Florida Senate, District 10

File signed original with committee office

S-020 (03/2004)

250328

LEGISLATIVE ACTION

Senate . House

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The Committee on Banking and Insurance (Simmons) recommended the following:

Senate Amendment (with title amendment)

Between lines 45 and 46
insert:

This paragraph does not apply to a new policy that was removed from Citizens Property Insurance Corporation through a take-out or assumption agreement.

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

250328

And the title is amended as follows:

Delete line 6

and insert:

inspection forms; providing that such requirement does not apply to certain new policies removed from Citizens Property Insurance Corporation; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 1130
INTRODUCER:	Senator Simmons
SUBJECT:	Windstorm Premium Discounts
DATE:	March 9, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Pre-meeting**
2.			CA	
3.			FP	

I. Summary:

SB 1130 requires insurers, when writing new policies and applying mitigation discounts, to only accept as valid the most recently approved uniform wind mitigation verification inspection form or a previously approved form completed within 5 years of the effective date of the new policy.

II. Present Situation:

Uniform Mitigation Verification Inspection Form

Section 627.0629, F.S., requires rate filings for residential property insurance to include actuarially reasonable discounts, credits, or other rate differentials, or appropriate reductions in deductibles to consumers who implement windstorm damage mitigation techniques to their properties. The windstorm mitigation measures that must be evaluated for purposes of mitigation discounts include fixtures or construction techniques that enhance roof strength; roof covering performance; roof-to-wall strength; wall-to-floor foundation strength; opening protections; and window, door, and skylight strength.

Section 627.711, F.S., requires insurers to clearly notify an applicant or policyholder of a personal lines residential property insurance policy of the availability and range of each premium discount, credit, other rate differential, or reduction in deductibles, for wind mitigation. The notice must be provided when the policy is issued and upon each renewal. The notification must be done on a form developed by the Office of Insurance Regulation, known as the Notice of Premium Discounts for Hurricane Loss Mitigation.

To qualify for a hurricane premium discount, consumers must submit a completed Uniform

Mitigation Verification Inspection Form developed by rule by the Financial Services Commission.[1] Changes to the most current uniform wind mitigation verification inspection form were adopted in January of 2012.[2] The current uniform wind mitigation verification inspection form states that it is valid for up to 5 years provided no material changes have been made to the structure, however, an insurer when issuing a policy to a new policyholder can request a new inspection be completed prior to a completed form being older than 5 years. Furthermore, an insurer at its own expense may at any time require a uniform wind mitigation verification inspection form to be independently verified by a qualified inspector, inspection company or third party quality assurance provider.[3]

Certified Wind Mitigation Inspector

Under current law an insurer must accept a uniform mitigation verification form signed by an authorized mitigation inspector. Those who qualify as an authorized mitigation inspector include:

- A home inspector licensed under s. 468.8314, F.S., who has completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board which includes hurricane mitigation techniques and compliance with the uniform mitigation verification form and completion of a proficiency exam;
- A building code inspector certified under s. 468.607, F.S.;
- A general, building, or residential contractor licensed under s. 489.111, F.S.;
- A professional engineer licensed under s. 471.015, F.S.;
- A professional architect licensed under s. 481.213, F.S.; or
- Any other individual or entity recognized by the insurer as possessing the necessary qualifications to properly complete a uniform mitigation verification form.

A person who is authorized to sign a mitigation verification form must inspect the structures referenced by the form personally, not through employees or other persons, and must certify or attest to personal inspection of the structures referenced by the form. However, licensed engineers under s. 471.015, F.S., and licensed contractors s. 489.111, F.S., may authorize a direct employee, who is not an independent contractor, and who possesses the requisite skill, knowledge and experience, to conduct a mitigation verification inspection. Insurers have the right to request and obtain information regarding any authorized employee's qualifications prior to accepting a mitigation verification form.

An authorized mitigation inspector that signs a uniform mitigation form and a direct employee authorized to conduct mitigation verification inspections may not commit misconduct when performing an inspection. Misconduct occurs when an authorized mitigation inspector signs a uniform mitigation verification form that:

- Falsely indicates that he or she personally inspected the structures referenced by the form;
- Falsely indicates the existence of a feature which entitles an insured to a mitigation discount which the inspector knows does not exist or did not personally inspect;
- Contains erroneous information due to the gross negligence of the inspector; or

[1] Rule 69O-170.0155, F.A.C.
[2] *Id.*
[3] s. 627.711(8), F.S.

- Contains a pattern of demonstrably false information regarding the existence of mitigation features that could give an insured a false evaluation of the ability of the structure to withstand major damage from a hurricane endangering the safety of the insured's life and property.

The licensing board of an authorized mitigation inspector may commence disciplinary proceedings and impose administrative fines and other sanctions for such misconduct violations.

III. Effect of Proposed Changes:

Section 1 Requires insurers, when writing new policies and applying mitigation discounts, to only accept as valid the most recently approved uniform wind mitigation verification inspection form or a previously approved form completed within 5 years of the effective date of the new policy.

Section 2 The effective date of the bill is July, 1 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Policyholders who switch insurers and previously had a mitigation inspection that was completed on a previously approved form more than 5 years ago will need to pay for a new inspection in order for their new insurer to allow the mitigation credits.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 627.711 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Simmons

10-00492B-15 20151130__

A bill to be entitled

An act relating to windstorm premium discounts; amending s. 627.711, F.S.; providing that an insurer issuing a policy to a new policyholder may accept as valid only specified uniform mitigation verification inspection forms; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) of section 627.711, Florida Statutes, is amended, and paragraph (c) is added to that subsection, to read:

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

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

1. A home inspector licensed under s. 468.8314 who has completed at least 3 hours of hurricane mitigation training approved by the Construction Industry Licensing Board which includes hurricane mitigation techniques and compliance with the uniform mitigation verification inspection form and completion

10-00492B-15 20151130__

of a proficiency exam;

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

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

4. A professional engineer licensed under s. 471.015;

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

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

(c) An insurer issuing a policy to a new policyholder may accept as valid only the uniform mitigation verification inspection form:

1. Most recently adopted by the commission by rule; or

2. Previously adopted by the commission by rule if the form was completed within 5 years preceding the effective date of the new policy.

Section 2. This act shall take effect July 1, 2015.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: March 3, 2015

I respectfully request that **Senate Bill 1130**, relating to Windstorm Premium Discounts, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator David Simmons
Florida Senate, District 10

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 830
INTRODUCER:	Senator Simmons
SUBJECT:	Regulation of Corporation Not for Profit Self-insurance Funds
DATE:	March 3, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			CM	
3.			FP	

I. Summary:

SB 830 expands the types of entities that are eligible to be members of a corporation not for profit self-insurance fund authorized under s. 624.4625, F.S. In 2007, the Legislature authorized two or more not-for-profit corporations to create a self-insurance fund for purposes of pooling property or casualty insurance, if each member of the fund receives at least 75 percent of its revenue from governmental sources, and other conditions are met.[1] SB 830 maintains this requirement but also allows publicly supported organizations under section 501(c)(3) of the Internal Revenue Code receiving at least 75 percent of its support from a governmental unit or the public, to be a member of the fund. The eligibility of such an entity would be supported on the most recent Internal Revenue Service Form 990 or Form 990EZ and Schedule A.

II. Present Situation:

Regulation of Self-Insurance Funds

The Office of Insurance Regulation (OIR) regulates the activities of insurers and other risk-bearing entities.[2] As an alternative to obtaining insurance from a licensed insurance company, the current law allows certain persons to form and obtain insurance coverage from a self-insurance fund. Generally, the members of a self-insurance fund assume the risk of loss among themselves, rather than transferring the risk to an insurance company.[3]

[1] Section 14, chapter 2007-1, Laws of Florida.

[2] Section 20.121(3)(a)1., F.S.

[3] The Commercial Self-Insurance Fund Act (ss. 624.460-624.488, F.S.), authorizes certain groups and associations to form a commercial self-insurance fund, subject to the approval of OIR. Under s. 624.4621, F.S., two or more employers may pool their workers' compensation liabilities and form a self-insurance fund for workers' compensation purposes, referred to as a group self-insurance fund. Such funds must comply with administrative rules adopted by the Financial Services Commission. Pursuant to s. 624.4622, F.S., any two local governments may enter into interlocal agreements to create a self-insurance fund for securing the payment of benefits under the workers' compensation law. Under s. 624.4623, F.S., any two or more independent non-profit colleges or universities may form a self-insurance fund for the purpose of pooling and spreading

Section 624.4625, F.S., provides that two or more not-for-profit corporations[4] located and organized under Florida law may form a self-insurance fund. The purpose of the self-insurance fund must be to pool and spread the property and casualty liabilities of group members. The fund must meet a number of requirements including that it:

- Has annual normal premiums in excess of $5 million;
- Has only members who receive at least 75 percent of its revenues from local, state, or federal governmental sources;
- Uses a qualified actuary to determine actuarially sound rates and adequate reserves and submits annual certifications to the OIR;
- Maintains excess insurance coverage; and
- Submits an annual audited financial report to the OIR.

A corporation not for profit self-insurance fund that meets the requirements of this section is not an insurer for purposes of participation in or coverage by any guaranty association established under ch. 631, F.S. Further, such a self-insurance fund is not subject to s. 624.4621, F.S., and is not required to file any report with the Department of Financial Services under s. 440.38(2)(b), F.S., that is uniquely required of group self-insurer funds qualified under s. 624.4621, F.S.

Florida Insurance Trust

The Florida Insurance Trust (FIT) is a corporation not for profit self-insurance fund created in 2007. Currently, FIT has approximately 175 participating non-profit social service entities.[5] According to representatives of FIT, the existing statutes provide for a potential field of membership of 9,000, of which only 175 are currently members. FIT provides property, general liability, professional liability, employment practice liability, workers compensation, health insurance, and commercial automobile coverage to its members.

FIT is required to ensure that all members are eligible pursuant to s. 624.4625, F.S. Any potential member is required to submit a notarized certification, signed by an officer of the member, that at least 75 percent of funding comes from governmental sources as required under s. 624.4625, F.S. Each member must submit Form 990 for review and, if necessary, audited financial statements to confirm compliance with eligibility requirements. [6] Recently, during an OIR inquiry into FIT's process for determining eligibility of members, FIT noted that four entities did not meet statutory eligibility requirements.[7] According to the OIR, FIT represented that these accounts have been nonrenewed. Based on the results of its inquiry, the OIR does not have any objections to the manner in which FIT reviews eligibility. The OIR determined that none of the entities brought to its attention, except for the four entities referenced above, were ineligible for membership.

liabilities of its group members in any property or casualty risk or surety insurance or securing the payment of benefits under the workers' compensation law.

[4] Section 617.1803, F.S., defines the term, "corporation not for profit" to mean a corporation no part of the income or profit of which is distributable to its members, directors, or officers, except as otherwise provided under this chapter.

[5] Florida Insurance Trust, *Florida Insurance Trust Current Membership Overview* (February 27, 2015) (on file with the Senate Committee on Banking and Insurance).

[6] Office of Insurance Regulation letter to the Florida Insurance Trust (July 25, 2014) (on file with the Senate Banking and Insurance Committee).

[7] *Id*.

In the event premiums are inadequate, the trustees of FIT, or an agency or court of competent jurisdiction may assess members of FIT for payment of the obligations of FIT as necessary based proportionately on premiums earned from each member. If one or more members fail to pay the assessment, the other members are liable on a proportionate basis for an additional assessment.

Section 501(c)(3) Tax Exempt Organizations

Organizations described in section 501(c)(3) of the Internal Revenue Code are commonly referred to as *charitable organizations*. To qualify as exempt from federal income tax, an organization must meet requirements set forth in the Internal Revenue Code and apply for recognition of an exemption. For section 501(c)(3) organizations, the law provides only limited exceptions to this requirement. Applying for recognition of an exemption results in formal IRS recognition of an organization's status, and may be preferable for that reason. To be tax-exempt under section 501(c)(3) of the Internal Revenue Code, an organization must be organized and operated exclusively for exempt purposes[8] set forth in section 501(c)(3) of the Internal Revenue Code, and none of its earnings may inure to any private shareholder or individual.[9]

Generally, exempt organizations, other than private foundations, that are described in section 501(c)(3) must file their annual information returns on Form 990 or 990-EZ, unless excepted from filing and must also complete Schedule A. Schedule A is used to report and substantiate information about an organization's public charity status and public support.

III. Effect of Proposed Changes:

SB 830 expands the types of entities that are eligible to be members of a corporation not for profit self-insurance fund authorized under s. 624.4625, F.S. Currently, two or more not-for-profit corporations may create a self-insurance fund for purposes of pooling property or casualty insurance, if each member of the fund receives at least 75 percent of its revenue from governmental sources, and other conditions are met.[10] SB 830 maintains this requirement and allows publicly supported organizations under section 501(c)(3) receiving at least 75 percent of its support from a governmental unit or the public, to be a member of the fund. The eligibility of such an entity would be evidenced on the most recent Internal Revenue Service Form 990 or Form 990EZ and Schedule A.

The bill would take effect July 1, 2015.

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[8] The exempt purposes set forth in section 501(c)(3) are charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international amateur sports competition, and preventing cruelty to children or animals. The term *charitable* is used in its generally accepted legal sense and includes relief of the poor, the distressed, or the underprivileged; advancement of religion; advancement of education or science; erecting or maintaining public buildings, monuments, or works; lessening the burdens of government; lessening neighborhood tensions; eliminating prejudice and discrimination; defending human and civil rights secured by law; and combating community deterioration and juvenile delinquency. *See* http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/Exempt-Purposes-Internal-Revenue-Code-Section-501(c)(3) (last visited February 28, 2015).

[9] *See* Internal Revenue Service, *Frequently Asked Questions about Applying for Tax Exemption* accessible at*:* http://www.irs.gov/Charities-&-Non-Profits/Frequently-Asked-Questions-About-Applying-for-Tax-Exemption (last visited February 28, 2015).

[10] Section 14, chapter 2007-1, Laws of Florida.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Indeterminate. Premiums, contributions, and assessments received by a corporation not for profit self-insurance fund are subject to the premium tax, like insurers, except that the tax rate is 1.6 percent (instead of 1.75 percent) of the gross amount of such premiums, contribution, and assessments.

B. Private Sector Impact:

The bill would allow public support organizations that are 501(c)(3) entities and receive 75 percent of their support from public or governmental sources to become members of a corporation not for profit self-insurance fund organized under s. 624.4625, F.S. By allowing such entities to self-insure as a group, in lieu of obtaining insurance from the private market, such corporations may realize a savings on insurance premiums, assuming the fund has lower expenses than private insurers or more favorable loss experience than insured plans.

According to representatives of the Florida Insurance Trust, SB 830 would allow additional classes of business including Goodwill Industries, Boys & Girls Clubs, food banks, rescue missions (homeless shelters), Salvation Army, Big Brothers Big Sisters, and YMCAs to become members. FIT estimates that the bill would increase the number of additional eligible entities by 125 to 150 entities. FIT asserts that there are a finite number of entities for each of these classes in Florida (9 Goodwill Industries, 41 Boys & Girls Clubs, and 24 YMCAs) that would become members.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 624.4625 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Simmons

10-00263B-15 2015830__

A bill to be entitled

An act relating to the regulation of corporation not for profit self-insurance funds; amending s. 624.4625, F.S.; revising the requirements for a participating member of a corporation not for profit self-insurance fund; providing an effective date.

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

Section 1. Paragraph (b) of subsection (1) of section 624.4625, Florida Statutes, is amended to read:

624.4625 Corporation not for profit self-insurance funds.—

(1) Notwithstanding any other provision of law, any two or more corporations not for profit located in and organized under the laws of this state may form a self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any one or combination of property or casualty risk, provided the corporation not for profit self-insurance fund that is created:

(b) Requires for qualification that each participating member receive at least 75 percent of its revenues from local, state, or federal governmental sources or a combination of such sources or be a publicly supported organization under s. 501(c)(3), which receives at least 75 percent of its support from a governmental unit or the public as evidenced on the organization's most recent Internal Revenue Service Form 990 or Form 990-EZ and Schedule A.

Section 2. This act shall take effect July 1, 2015.

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

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: February 23, 2015

I respectfully request that **Senate Bill 830**, relating to Regulation of Corporation Not for Profit Self-insurance Funds, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator David Simmons
Florida Senate, District 10

File signed original with committee office

S-020 (03/2004)