Tab 1	**SB 102** by **Steube**; (Identical to H 0579) Payment of Health Care Claims

Tab 2	**SB 262** by **Steube**; (Identical to H 0675) Health Insurance

Tab 3	**SB 404** by **Simmons**; Legislative Ratification

Tab 4	**SB 420** by **Brandes**; (Similar to H 0813) Flood Insurance

676588	A	S		RS	BI, Brandes	Delete L.148 - 150:	02/21 01:59 PM
670196	SA	S		RCS	BI, Brandes	Delete L.148 - 152:	02/21 01:59 PM
283966	A	S	L	RCS	BI, Brandes	Delete L.41 - 94:	02/21 01:59 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Flores, Chair
Senator Steube, Vice Chair

MEETING DATE: Tuesday, February 21, 2017
TIME: 12:30—3:00 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Flores, Chair; Senator Steube, Vice Chair; Senators Bracy, Braynon, Farmer, Gainer, Garcia, Mayfield, and Thurston

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 102** Steube (Identical H 579)	Payment of Health Care Claims; Prohibiting a health insurer from retroactively denying a claim under specified circumstances, etc. BI 02/21/2017 Favorable HP RC	Favorable Yeas 9 Nays 0
2	**SB 262** Steube (Identical H 675)	Health Insurance; Deleting a provision that provides that health maintenance organizations are not vicariously liable for certain medical negligence except under certain circumstances; authorizing specified persons to bring a civil action against a health maintenance organization for certain violations; specifying a health maintenance organization's liability for such violations, etc. BI 02/21/2017 Favorable JU RC	Favorable Yeas 6 Nays 3
3	**SB 404** Simmons	Legislative Ratification; 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 when the adverse impact or regulatory costs of such allowances or manuals exceed any criteria specified in provisions, etc. BI 02/21/2017 Favorable GO RC	Favorable Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 420** Brandes (Similar H 813)	Flood Insurance; Revising the intervals at which specified standards and guidelines for projecting certain rate filings must be revised by the Florida Commission on Hurricane Loss Projection Methodology; authorizing an insurer to issue flood insurance policies on a flexible basis; specifying a condition for an eligible surplus lines insurer before a surplus lines agent may be excepted from a diligent-effort requirement when exporting flood insurance contracts or endorsements to the insurer, etc. BI 02/21/2017 Fav/CS CA RC	Fav/CS Yeas 8 Nays 1

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 102
INTRODUCER:	Senator Steube
SUBJECT:	Payment of Health Care Claims
DATE:	February 20, 2017
REVISED:	2/21/17

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Favorable**
2.			HP	
3.			AP	

I. Summary:

SB 102 prohibits health insurers and health maintenance organizations (HMOs) from retroactively denying a claim, if at any time, the insurer or HMO verified the eligibility of an insured or subscriber at the time of treatment and provided an authorization number. Currently, a health insurer or HMO may retroactively deny a claim because of an insured's ineligibility up to 1 year after the payment of the claim. Under existing law, the patient is responsible for those claims, which potentially exposes the physician to financial risk if the patient does not pay the claims.

II. Present Situation:

Denial of Claims

According to the American Medical Association (AMA), health care providers lose a significant amount of administrative time and revenue due to denied claims. In 2013, the AMA estimated that more than $43 billion in savings could have been realized since 2010 if commercial insurers had consistently paid claims correctly.[1]

Coverage for medical services can be denied before or after the service has been provided, through denial of preauthorization requests, through denial of claims for payment, or a retroactive denial of payment. As a condition for coverage of some services, providers or insureds are required to request authorization prior to providing or receiving the service. The full claim or certain lines of the claim may be denied, such as a surgery with charges for multiple procedures and supplies.

[1] Amednews.com, *Claims Analysis Shows Doctors the Way to Fight Insurer Denials* (Jul. 15, 2013) (on file with Senate Committee on Banking and Insurance).

There are many possible reasons for claim denials. Claims may be denied due to an incorrect diagnosis code, incomplete claim submission, or the submission of a duplicate claim. Eligibility issues can cause claims to be denied. For example, a claim may be submitted for a service provided prior to an individual's effective date of coverage or after it has been terminated. Finally, claim denials can occur when a determination is made that the service provided was not covered or it was not medically necessary. Under state and federal laws, denied claims may be appealed.

After an insurer or HMO pays a claim, the insurer or HMO may conduct a claims audit to verify claims were paid appropriately and accurately. Such an audit can be triggered by a variety of reasons. Some of these situations include new billing guidelines have been established by regulators; provider has made significant changes to the original bill, such as the diagnosis of the patient; the plan is notified that the enrollee's coverage is terminated due to non-payment of premiums; or the plan is notified that the enrollee has other health insurance coverage. After the audit, an insurer or HMO may retrospectively deny a claim for a preauthorized service and try to recoup the payment from the provider. Reasons for the retroactive denial may include fraud, submission of incomplete or inaccurate information; nonpayment of premiums; exhaustion of benefits; coordination of benefits; or if the individual was not enrolled or eligible for coverage at the time services were rendered. As a result, an insurer or HMO may try to recoup payment from a provider by retroactively denying a previously paid claim.

Group Health Plans Retroactive Termination of Coverage

Retroactive termination of insurance coverage to an earlier date due to an employee's discharge is an increasing problem for some providers and consumers. Some plans may allow an employer to cancel coverage of an employee retroactively more than 90 days post termination. Other plans will accept retroactive terminations for up to the preceding 3 months, if the plan has not paid any claims for the enrollee during that period. If claims have been paid within the previous 60 days, the coverage termination date may be established as of the end of the month in which services were rendered.

When a provider is notified of a retroactive termination, the provider may have already verified that the patient was covered, rendered services in reliance and expectation of payment, and even received payment. Retroactive terminations often result in the provider or the consumer bearing the loss, despite the verified eligibility.

Individuals Exchange Plans and Premium Tax Credits

The federal Patient Protection and Affordable Care Act (PPACA)[2] guarantees access to coverage and mandates certain essential health benefits and other requirements. To address affordability issues, federal premium tax credits and cost-sharing subsidies are available to assist eligible low and moderate-income individuals to purchase qualified health plans (QHPs) on a state or federal

[2] The Patient Protection and Affordable Care Act (Pub. Law No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111–152), which amended several provisions of the PPACA, was enacted on March 30, 2010.

exchange.[3] In Florida, 1,588,628 individuals (or 91 percent of the total individuals) enrolled through the federal exchange received premium tax credits for plan year 2016.[4]

Under PPACA, insurers and HMOs must provide a grace period[5] of at least three consecutive months[6] before cancelling the policy or contract of a federally subsidized enrollee who is delinquent if the enrollee previously paid 1-month's premium. During the grace period, the insurer must pay all appropriate claims for services provided during the first month of the grace period. For the second and third months, an insurer may pend claims. Issuers must notify providers that may be affected that an enrollee has lapsed in his or her payment of premiums and there is a possibility the issuer may deny the payment of claims incurred during the second and third months.[7]

If the enrollee resolves all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and third month would be denied. If coverage is terminated, the termination date is the last day of the first month of the grace period and the insurer may not recoup any payment for claims made during the first month of the grace period. At the end of grace period, the provider may seek payment for the medical services the insurer denied for months two and three. Providers note that it will be extremely difficult to obtain direct payment from patients receiving federal subsidies given their low or moderate income.[8] According to a 2014 survey, 48 percent of the providers not participating with any PPACA exchange products cited concerns about assuming financial liability during the grace period as a reason for their decision.[9]

Regulation of Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities.[10] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a

[3] In general, individuals and families may be eligible for the premium tax credit if their household income for the year is at least 100 percent but no more than 400 percent of the federal poverty line for their family size. For residents of one of the 48 contiguous states or Washington, D.C., the following illustrates when household income would be at least 100 percent but no more than 400 percent of the federal poverty line in computing your premium tax credit for 2015:
$11,880 (100%) up to $46,680 (400%) for one individual; $16,020 (100%) up to $62,920 (400%) for a family of two; and $20,160 (100%) up to $95,400 (400%) for a family of four. ASPE Research Brief, *Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace*, (Oct. 24, 2016) available at https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit (last viewed Feb. 6, 2017).
[4] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016(*Apr. 12, 2016), available at https://aspe.hhs.gov/pdf-report/marketplace-premiums-after-shopping-switching-and-premium-tax-credits-2015-2016 (last viewed Feb. 19, 2017).
[5] Example of grace period: Premium is not paid in May. Premium payments are made in June and July. Grace period would end July 31. Coverage would be cancelled retroactively to the last day of May. See https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/ (last viewed Feb. 19, 2017).
[6] 45 C.F.R. s. 155.430.
[7] 45 C.F.R. s. 156.270.
[8] American Hospital Association, *et al*, Letter to Ms. Tavenner, Centers for Medicare and Medicaid Services (Aug. 15, 2013) (on file with Senate Committee on Banking and Insurance).
[9] Tracy Gnadinger, Health Policy Brief: The Ninety-Day Grace Period, (Oct. 16, 2014) available at: http://healthaffairs.org/blog/2014/10/17/health-policy-brief-the-ninety-day-grace-period/ (last viewed Feb. 17, 2017).
[10] Section 20.121(3), F.S.

certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.[11]

Florida's Prompt Payment Laws

Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans in accordance with ss. 627.6131and 641.3155, F.S., respectively.[12] These provisions delineate the rights and responsibilities of insurers, HMOs, and providers for the payment of claims. An insurer or HMO has 12 months after payment is made to a provider to make a claim for overpayment against the provider, if the provider is licensed under ch. 458, F.S., (physicians), ch. 459, F.S., (osteopaths), ch. 460, F.S., (chiropractors), ch. 461, F.S., (podiatrists), or ch. 466, F.S., (dentists). For all other types of providers, an insurer or HMO has up to 30 months after such payment to make a claim for overpayment.[13] The law provides a process and timeline for providers to pay, deny, or contest the claim. Further, the law prohibits an insurer or HMO from retroactively denying a claim because of the ineligibility of an insured or subscriber more than 1 year after the date the claim is paid.

Grace Periods

The federal regulation governing grace periods for federally subsidized policies or contracts does not affect policies or contracts of individuals who are not enrolled in an exchange QHP or who are enrolled in an exchange QHP and do not receive a subsidy. The grace period for these individual policies or contracts remain at the length required under Florida law,[14] which varies by the duration of the premium payment interval. During the grace period, the policy or contract stays in force. The policy is in force during the grace period, thus the insurer or HMO must affirm that an individual is insured, even when the payment is late and remains unpaid during the grace period. If the insurer or HMO does not receive the full payment of the premium by the end of the grace period, coverage terminates as of the grace period start date and the insurer or HMO may retroactively deny any claims incurred during the grace period.

Division of State Group Insurance

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan consistent with section 125, Internal Revenue Code. To administer the

[11] Section 641.21(1), F.S.

[12] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organization , and individual and group contracts that only provide direct payments to dentists.

[13] Section 627.6131, F.S., and 641.3155, F.S., provide exceptions to this time limit in cases relating to fraud.

[14] Sections 627.608 and 641.31(15), F.S. The grace period of an individual policy must be a minimum of 7 days for weekly premium; 10 days for a monthly premium; and 31 days for all other periods. The grace period of a HMO contract must be at least 10 days. For group policies, if cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due. [Section 627.6645, F.S.]. See 45 C.F.R. s. 155.735 for provisions relating to the termination of Small Business Health Options Program (SHOP) enrollment or coverage obtained through an exhange.

state group health insurance program, DMS contracts with third party administrators for self-insured health plans and insured health maintenance organizations (HMOs), as well as a pharmacy benefits manager for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

Florida's Statewide Medicaid Managed Care Program

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, the Agency for Health Care Administration (AHCA) oversees the Medicaid program. The Department of Children and Families (DCF) conducts Medicaid eligibility determinations.[15] The Statewide Medicaid Managed Care (SMMC) program[16] has two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. The AHCA contracts with managed care plans to provide services to eligible recipients. The MMA program covers medical and acute care services for plan enrollees. Most Florida Medicaid recipients who are eligible for the full array of Florida Medicaid benefits are enrolled in an MMA plan. The LTC program covers nursing facility and home and community-based services to eligible adults.

Medicaid managed care plans are responsible for paying claims in accordance with federal and state law and contractual requirements. Florida Medicaid managed care plans are required to comply with s. 641.3155, F.S.,[17] which allows HMOs to deny a claim retroactively because of an insured or subscriber ineligibility up to 1 year after the date of payment of the claim.

After paying claims pursuant with the deadlines in s. 641.3155, F.S., an HMO may audit claims to verify payment was appropriate and accurate. As a result, an HMO may try to recoup payment from a provider for claims paid in error. It may do this by reducing payments currently owed the provider, withholding future payments, or otherwise requiring a refund from the provider.

Section 409.913(1)(e), F.S., defines "overpayment" to include any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake. Section 409.907, F.S., prohibits AHCA from demanding repayment from a provider in any instance in which the Medicaid overpayment is attributable to error of the Department of Children and Families in the determination of eligibility of a recipient, which is an insignificant number. [18]

The Insurance Codes does not define the term "eligibility." In the context of the Medicaid program, the term "eligibility" may refer to the recipient's financial eligibility for the Medicaid program (income and general requirements, such as a resident of the state) or clinical eligibility

[15] See http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid. The Social Security Administration makes determination for recipients of Supplemental Security Income. (last viewed Feb. 17, 2017).
[16] Part IV of ch. 409, F.S.
[17] Section 409.967(2)(j), F.S.
[18] The Department of Children and Families conducts random sample quality control reviews on all programs for which they determine eligibility. The DCF provided data for calendar year 2016. For the Family Medicaid program, 24,278 reviews conducted; three errors were found for retroactive Medicaid approved but not applied for; and 132 errors were found for retroactive Medicaid requested but not approved when it should have been. For the Medically Needy program, 9,621 reviews were conducted; four errors were found for retroactive Medicaid approved but not applied for and 19 errors were found for retroactive Medicaid requested but not approved when it should have been. Department of Children and Families email (Feb. 20, 2017) on file with Senate Committee on Banking and Insurance Committee).

(e.g., whether the service is medically necessary). An individual can be deemed ineligible retroactively if the individual provided inaccurate or incomplete information during the application or renewal process, failed to report a change, or DCF made an error when determining eligibility.[19]

The Florida Medicaid Provider General Handbook and Florida Medicaid service-specific coverage policies and handbooks, incorporated by reference in the SMMC contract, require providers to verify each recipient's eligibility each time they render a service. A managed care plan may issue prior authorization for services, ranging from a single event to months of service. When a prior authorization is tied to multiple dates of service, the provider must be responsible for re-verifying the recipient's eligibility at the time each service is delivered, as the managed care plan is not involved in, and will not know, the individualized schedule for delivery of the service. Furthermore, when an authorization spans multiple dates of service, an enrollee's eligibility for service may change from one month to the next. An authorization may be granted on a date when eligibility is confirmed, but the enrollee may become ineligible in a subsequent month. Although an enrollee may have eligibility on file at the time the service was authorized, the enrollee may have become ineligible on the date of service for additional reasons (e.g., enrollee has become deceased or moved to a setting in which Medicaid payment is prohibited).

Section 1903(d)(2)(C) of the Social Security Act states, "When an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1 year period, whether or not recovery was made."

Federal regulation[20] implementing this requirement distinguishes between discovery of an overpayment attributable to fraud or abuse as compared with other overpayment situations. While in most situations, discovery of an overpayment is deemed to occur when any state official first notifies a provider in writing of an overpayment and specifies an overpayment amount, the regulations[21] provide that [a]n overpayment that results from fraud is discovered on the date of the final written notice of the state's overpayment determination that a Medicaid agency official or other state official sends to the provider. Florida Medicaid managed care plans are contractually required to comply with both of the above provisions. Because of recoupment of overpayments, states are required to return the federal matching portion on recoveries made by the state or the health plan.

III. Effect of Proposed Changes:

Sections 1 and 2 of the bill amend ss. 627.6131 and 641.3155, F.S., respectively, to prohibit a health insurer or an HMO from retroactively denying a claim because of an insured's ineligibility

[19] Department of Children and Families memo (Jan. 25, 2017) (on file with Senate Committee on Banking and Insurance). Examples of changes affecting eligibility include pregnancy, birth of child, receipt of new or increased earnings, termination of employment, changes in living arrangement, and address.
[20] 42 C.F.R. s. 433.316.
[21] 42 C.F.R. s. 433.304 and 42 C.F.R. s. 433.316(d).

at any time if the health insurer or HMO had previously verified the eligibility of an insured at the time of treatment and provided an authorization for payment.
Sections 627.608, F.S., and 641.31(15), F.S. require individual health insurance policies and all health maintenance contracts, excluding federally subsidized plans, to have a grace period of not less than 7 days and up to 31 days. If any required premium is not paid on or before the due date, it may be paid during the following grace period. During the grace period, the contract stays in force. If full payment of the premium is not received by the end of the grace period, coverage terminates as of the grace period start date, and the insurer or HMO will retroactively deny any claims incurred during the grace period. For a group policy, if cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due. [22]

Currently ss. 627.6131, F.S., and 641.3155, F.S., limit the ability of a HMO or insurer to deny a claim retroactively because of insured ineligibility to 1 year after the date of payment of the claim. The bill would require HMOs and insurers to pay claims incurred during the grace period and any other time for policies or contracts that were not eligible for the federal premium tax credit , if the provider verified the insured as eligible at the time of treatment and was provided an authorization number by the insurer or HMO.

Section 3 provides this act takes effect July 1, 2017.

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.

[22] Section 627.6645, F.S.

B. Private Sector Impact:

Eliminating the ability of a health insurer or HMO to recoup the payment of a claim for an authorized treatment for an individual previously deemed eligible will prevent unanticipated additional financial obligations to a patient and potential unexpected loss of revenues to a provider. This will simultaneously impose additional financial liability on a health insurer or HMO that provides authorization for an individual who is later deemed ineligible for coverage.

Federal regulations govern the grace period and payment of claims of individuals receiving federally subsidized products on the exchange. This bill would not apply to such claims.

C. Government Sector Impact:

Division of State Group Insurance. According to DMS, the two fully insured plans (Capital Health Plan and Florida Health Care Plans), would be impacted by the bill. The initial estimated impact ranges from seven cents (+.07) per member, per month, to a yearly impact of up to 1.4 million dollars. The financial impact of the bill may be shifted to the state by way of a rate adjustment to offset associated losses.[23]

Florida's Medicaid Program. According to the AHCA, the bill would prevent Florida Medicaid managed care plans from recouping overpayments from their providers if they had previously verified eligibility and provided an authorization number. The State of Florida is responsible for submitting to the federal government the federal share of any overpayments recovered by the state or a health plan. To ensure Florida Medicaid managed care plans can continue to seek return of payment from a provider because of audit findings and meet the state's obligation to return federal matching funds, the bill may require clarification of the Florida Medicaid managed care plans' ability to recoup overpayments in the case of inappropriate payments.[24]

This bill would result in an indeterminate fiscal impact to Florida Medicaid. Florida Medicaid payments to managed care plans could potentially increase due to managed care plans not being able to demand or recoup overpayments from their providers for retroactive denials.[25]

VI. Technical Deficiencies:

None.

[23] Department of Management Services, *Senate Bill 102 Fiscal Analysis* (Dec. 28, 2016) (on file with the Senate Committee on Banking and Insurance).
[24] Agency for Health Care Administration, *Senate Bill 102 Fiscal Analysis* (Dec. 9, 2016) (on file with the Senate Committee on Banking and Insurance).
[25] *Id.*

VII. Related Issues:

Internally, an insurer may understand an authorization to be a pre-service approval for certain benefits or services, a voluntary pre-certification request, or a pre-admission certification. Not all benefits or procedures require prior authorization. A plan may offer a reference number for the call. An insured, member, or provider may consider this their authorization number.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6131 and 641.3155.

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 Steube

23-00267-17 2017102__

A bill to be entitled

An act relating to the payment of health care claims; amending s. 627.6131, F.S.; prohibiting a health insurer from retroactively denying a claim under specified circumstances; amending s. 641.3155, F.S.; prohibiting a health maintenance organization from retroactively denying a claim under specified circumstances; providing an effective date.

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

Section 1. Subsection (11) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.—

(11) A health insurer may not retroactively deny a claim because of insured ineligibility:

(a) At any time, if the health insurer verified the eligibility of an insured at the time of treatment and provided an authorization number.

(b) More than 1 year after the date of payment of the claim.

Section 2. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility:

(a) At any time, if the health maintenance organization verified the eligibility of an insured at the time of treatment and provided an authorization number.

(b) More than 1 year after the date of payment of the claim.

Section 3. This act shall take effect July 1, 2017.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

102
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address 1000 Riverside Ave #240
Street

Jacksonville FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

SB 102
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Payment of Health Care Claims

Name Ms. Zayne Smith

Job Title Associate State Director

Address 200 W. College Ave
Street

Phone 850 228-4243

Tally FL 32301
City *State* *Zip*

Email zsmith@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

102
Bill Number (if applicable)

Topic Payment of Health Care Claims

Amendment Barcode (if applicable)

Name Wendes Troncoso

Job Title Vice President + General Counsel

Address 200 W. College Ave
Street

Phone 950-886-2804

City *State* *Zip*

Email

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

102
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Retroactively Denying a Claim

Name Chris Hansen

Job Title Ballard Partners

Address 403 E. Park Ave
Street

Tallahassee FL 32302
City *State* *Zip*

Phone 577-0444

Email Chansen@ballardfl.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Podiatric Medical Assoc. (FPMA)

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

110 SOB
12:30pm

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-21-2017
Meeting Date

SB 102 ✓
Bill Number (if applicable)

Topic PAYMENT OF HEALTH CARE CLAIMS

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DR
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

102
Bill Number (if applicable)

Topic Health Insurance

Amendment Barcode (if applicable)

Name Paul Lambert

Job Title

Address 263 Rosehill Drive North
Street

Tallahassee FL 32312
City *State* *Zip*

Phone 850 597-2696

Email plambert@paullambertlaw.com

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Chiropractic Association

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/21/17
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

102
Bill Number (if applicable)

Topic Retroactive Denials

Amendment Barcode (if applicable)

Name Dr Paul Bruning

Job Title Chief Operating officer

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Street

Phone 850-877-8174

TLH FL 32308
City *State* *Zip*

Email paul.bruning@flhoc.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Orthopedic Society, Florida Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

9/21/17
Meeting Date

102
Bill Number (if applicable)

Topic Retroactive Denials

Amendment Barcode (if applicable)

Name Marnie George

Job Title Sr. Advisor - Buchanan Ingersoll & Rooney

Address 101 North Monroe St Suite 1090 (*Street*)
Tallahassee FL 32301 (*City / State / Zip*)

Phone 850-510-8866

Email marnie.george@bipc.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Chapter American College of Cardiology

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

February 21, 2017
Meeting Date

SB102
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name Paul P. Sanford

Job Title _____

Address 106 South Monroe Street
Street

Phone 850-222-7200

Tallahassee FL 32301
City *State* *Zip*

Email paulsanf@aol.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Blue and Florida Insurance Council

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

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 262
INTRODUCER:	Senator Steube
SUBJECT:	Health Insurance
DATE:	February 20, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Favorable**
2.			JU	
3.			RC	

I. Summary:

SB 262 amends the Health Maintenance Organization Act to provide civil causes of action against health maintenance organizations for violations of the act and for acting in bad faith when failing to provide a covered service. The bill provides that any person may bring a civil action against a health maintenance organization (HMO) if the HMO fails to provide a covered service when the HMO in good faith should have provided such service had it acted fairly and reasonably toward the person and with due regard for his or her interests. The covered service must be medically reasonable or necessary in the independent medical judgment of the treating physician.

The bill creates individual causes of action against HMOs for violations of specified provisions of the HMO Act such as the prompt pay statute, statutes relating to unfair trade practices, and statutes relating to quality assurance.

This bill repeals provisions of law the Legislature passed in 2003 to limit HMO vicarious liability to actual employees of HMOs. The law repealed by this bill currently provides that health insurers, HMOs, prepaid health clinics, and prepaid health service organizations are not liable for the medical negligence of a health care provider with whom the entity has entered into a contract unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury or the provider is an employee of the entity.

II. Present Situation:

Health maintenance organizations ("HMOs") provide, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract. Services can include emergency care, inpatient hospital services, physician care, ambulatory diagnostic treatment, and preventive health care services. Service

providers, such as physicians, can be employees or partners in the HMO or they can contract with the HMO to provide services.[1] HMOs are regulated by parts I and III of ch. 641, F.S.[2]

Civil Liability of HMOs

In the late 1990s and early 2000s, the Legislature considered creating individual causes of actions against HMOs similar to the causes of action created by s. 624.155, F.S. In 1996, the Legislature passed CS/HB 1853, which created civil causes of action against HMOs, created a bad faith cause of action similar to the cause of action for bad faith against insurers in s. 624.155, F.S., and provided for plaintiff attorney fees in certain situations. The Governor vetoed that bill. The Legislature considered similar bills providing for causes of action against HMOs in 1997-2001 but those bills did not pass.[3]

Section 624.155, F.S., provides for various individual causes of action against insurers, including health insurers. It provides that any person may bring an action against an insurer when the person is damaged when the insurer does not attempt "in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests."[4] Section 641.201, F.S., provides that the s. 624.155, F.S., requirement that insurers act in good faith does not apply to HMOs.

In *Greene v. Well Care HMO, Inc.*,[5] the court considered whether a patient could bring an action against her HMO under the HMO Act[6] and whether a patient could bring a bad faith action. In that case, the patient's physician recommended treatment but the HMO denied coverage. The patient sought a second opinion and that physician agreed with the first doctor's recommendation. The HMO denied coverage in violation of the policy terms.[7] The court held that the HMO Act did not provide for a private cause of action against a HMO. The court also held that s. 624.155, F.S., did not apply to HMOs.[8]

In 2003, the Florida Supreme Court agreed with the *Greene* court and held that the HMO Act does not provide a private cause of action for violation of the Act's requirements.[9] However, the court held that the fact that there is no statutory cause of action does not preclude a common law negligence claim based on the same facts.[10] In *Villazon*, Villazon alleged that the physicians that had contracted with the HMO were agents or apparent agents of the HMO and, therefore, the HMO was responsible for the physicians' negligence and vicariously liable[11] for the death of his

[1] Section 641.19(12), F.S.
[2] Section 641.201, F.S.
[3] *See, e.g.*, HB 1547 (1997 Regular Session), SB 490 (1998 Regular Session), SB 216 (1999 Regular Session), SB 2154 (2000), and SB 2292 (2001 Regular Session).
[4] Section 624.155(1)(b)1., F.S.
[5] 778 So.2d 1037 (Fla. 4th DCA 2001).
[6] Section 641.17, F.S., names part I of ch. 641, F.S., the "Health Maintenance Organization Act."
[7] 778 So.2d at 1039.
[8] 778 So.2d at 1039-1041.
[9] *Villazon v. Prudential Health Care Plan*, 843 So.2d 842, 852 (Fla. 2003).
[10] *Villazon*, 843 So.2d at 852.
[11] Vicarious liability occurs when one person, although entirely innocent of any wrongdoing, is held responsible for the wrongful act of another. *See* 38 Florida Jurisprudence 2d s. 101. For example, an employer can be held vicariously liable for a tort committed by an employee.

wife.[12] The court held that the existence of an agency relationship is generally a question to be determined by the trier of fact and reversed the lower court's ruling on vicarious liability.[13]

In response to *Villazon*, the Legislature amended ss. 641.19 and 641.51, F.S., to provide that the HMO is not vicariously liable for the negligence of health care providers unless the provider is an employee of the HMO. The statutory amendments prohibited causes of action based on agency or apparent agency relationships.[14] The Legislature also created s. 768.0981, F.S., which provides:

> An entity licensed or certified under chapter 624, chapter 636, or chapter 641 shall not be liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract, other than an employee of such licensed or certified entity, unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury.

ERISA Preemption

The Employee Retirement Income Security Act of 1974 (ERISA), limits the remedies available to persons covered under private sector employer plans and preempts certain state laws. ERISA may preempt civil remedies in state courts, whether pursued under common law theories of liability or pursuant to a statutory cause of action. Most employer-sponsored health insurance and HMO plans are ERISA plans. ERISA does not apply to governmental plans and church plans. The act also has no application to individual health insurance plans. ERISA has a civil enforcement clause that provides a remedy in federal court for denied employee benefits. Employees and enrollees have a federal cause of action to either obtain the actual benefit that was denied, payment for the benefit, or a decree granting the administration of future benefits.[15] State tort remedies, on the other hand, allow for pain and suffering, lost wages and cost of future medical services.

In *Villazon*, the Florida Supreme Court held that ERISA did not preempt an action against an HMO alleging common law negligence and violations of the HMO Act.[16] A year after *Villazon*, the United States Supreme Court considered whether a Texas statute imposing liability on HMOs for failure to exercise ordinary care in making coverage decision was preempted by ERISA.[17] The court held that federal preemption applied and the remedies were limited to federal remedies.

Whether a claim against an ERISA plan is preempted is a fact-specific question. In *Badal v. Hinsdale Mem. Hosp.*,[18] the court held that claim was not preempted when the HMO was a defendant in the case under a theory of vicarious liability where the plaintiff alleged the HMO was responsible for the acts of its employees or agent. In determining whether ERISA

[12] *Villazon*, 843 So.2d at 845.
[13] *Villazon*, 843 So.2d at 853.
[14] *See* 2003-416, Laws of Florida.
[15] 29 U.S.C. s. 1132(a)(1).
[16] *Villazon*, 843 So.2d at 850-851.
[17] *Aetna Health v. Davila*, 542 U.S. 200 (2004).
[18] 2007 U.S. Dist. LEXIS 34713 (U.S. District Court Northern District of Illinois May 8, 2007).

preemption applies in medical malpractice cases, courts seem to look to see whether the malpractice is based on actions of a treating physician versus whether the injury was caused by a denial of coverage. In *Land v. Cigna Healthcare of Fla.*,[19] the court found ERISA preemption in a case where the treating physician ordered hospital admission for a patient but the HMO nurse did not approve a hospital stay.

III. Effect of Proposed Changes:

Vicarious Liability

The bill repeals provisions in ss. 641.19 and 641.51, F.S., providing that an HMO arranging the provision of heath care services does not create an actual agency, apparent agency, or employer-employee relationship for purposes of vicarious liability except when the provider is an actual employee of the HMO. This creates more situations where plaintiffs may allege negligence against HMOs on theories of vicarious liability.

Repeal of Section 768.0981, F.S.

The bill repeals s. 768.0981, F.S. That statute provides that an entity such as an insurer, prepaid limited health service organization, HMO, or prepaid health clinic[20] is not liable for the medical negligence of a health care provider with whom the entity has entered into a contract unless the entity expressly directs or exercises actual control over the specific conduct that caused injury. Repeal of this statute will allow more litigation against entities over whether they were vicariously liable for the medical negligence of health care providers under theories of actual or apparent agency.

HMO Bad Faith Liability

The bill creates a cause of action for bad faith against HMOs in specified situations. Specifically, it provides that a person may bring a civil action against an HMO if a person to whom a duty is owed suffers damage because of an HMO's failure to provide a covered service. The covered service must be one that the HMO should have been provided had the HMO acted in good faith and had acted fairly and reasonably toward the person with due regard for his or her interests. The service must have been medically reasonable or necessary in the independent medical judgment of a treating physician under contract with, or another physician authorized by, the HMO.

The court may award damages, including damages for mental anguish, loss of dignity, and any other intangible injuries, and punitive damages. In a bad faith action brought pursuant to the provisions of this bill, the court shall award a prevailing plaintiff reasonable attorney fees as part of the costs.

[19] 381 F.3d 1274 (11th Cir. 2004).
[20] Section 768.0981, F.S., specifically refers to entities licensed or certified under ch. 624, F.S., ch. 636, F.S., or ch. 641, F.S.

Causes of Action for Violations of the HMO Act

The bill creates an individual cause of action against an HMO if a person to whom a duty is owed suffers damage as a result of an HMO's violation of specified statutes: s. 641.3155, s. 641.3903(5), (10), (12), (13), or (14), and s. 641.51, F.S. In an action alleging violations of these statutes, the court shall award a prevailing plaintiff reasonable attorney fees as part of the costs.

Section 641.3155, F.S., is known as the "prompt pay" law. It requires the HMO to provide notice of receipt of provider claims within specified times, to deny or contest provider claims within specified times, and to pay provider claims within specified times.

Subsection 641.3903(5), F.S., prohibits certain unfair claim settlement practices by HMOs. An HMO may not:

- Attempt to settle claims on the basis of an application or any other material document which was altered without notice to, or knowledge or consent of, the subscriber or group of subscribers to a health maintenance organization; or
- Make a material misrepresentation to the subscriber for the purpose and with the intent of effecting settlement of claims, loss, or damage under a health maintenance contract on less favorable terms than those provided in, and contemplated by, the contract.

It is an unfair claim settlement practice if an HMO performs the following with such frequency as to indicate a general business practice:

- Failing to adopt and implement standards for the proper investigation of claims;
- Misrepresenting pertinent facts or contract provisions relating to coverage at issue;
- Failing to acknowledge and act promptly upon communications with respect to claims;
- Denying claims without conducting reasonable investigations based upon available information;
- Failing to affirm or deny coverage of claims upon written request of the subscriber within a reasonable time not to exceed 30 days after a claim or proof-of-loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the health maintenance organization;
- Failing to promptly provide a reasonable explanation in writing to the subscriber of the basis in the health maintenance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;
- Failing to provide, upon written request of a subscriber, itemized statements verifying that services and supplies were furnished, where such statement is necessary for the submission of other insurance claims covered by individual specified disease or limited benefit policies;
- Failing to provide any subscriber with services, care, or treatment contracted for pursuant to any health maintenance contract without a reasonable basis to believe that a legitimate defense exists for not providing such services, care, or treatment; or
- Engaging in systematic downcoding with the intent to deny reimbursement otherwise due.

Subsection 641.3903(10), F.S., prohibits an HMO from knowingly collecting any sum as a premium or charge for health maintenance coverage which is not then provided or is not in due course to be provided. An HMO may not knowingly collect as a premium or charge for health

maintenance coverage any sum in excess of or less than the premium or charge applicable to health maintenance coverage, in accordance with the applicable classifications and rates as filed with the Office of Insurance Regulation.

Subsection 641.3903(12), F.S., prohibits an HMO from engaging in or attempting to engage in discriminatory practices that discourage participation on the basis of the actual or perceived health status of Medicaid recipients. The statute also prohibits an HMO from refusing to provide services or care to a subscriber solely because medical services may be or have been sought for injuries resulting from an assault, battery, sexual assault, sexual battery, or any other offense by a family or household member or by another who is or was residing in the same dwelling unit.

Subsection 641.3903(13), F.S., prohibits an HMO from knowingly misleading potential enrollees as to the availability of providers.

Subsection 641.3903(14), F.S., prohibits any retaliatory action by an HMO against a contracted provider on the basis that the provider communicated information to the provider's patient regarding care or treatment options when the provider deems knowledge of such information by the patient to be in the best interest of the patient.

Section 641.51, F.S., requires an HMO to establish a quality assurance program and creates a requirement for second medical opinions in some cases. The HMO:

- Shall ensure that the health care services provided to subscribers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community;
- Shall have an ongoing internal quality assurance program for its health care services;
- Shall not have the right to control the professional judgment of a physician;
- Shall ensure that only a physician holding an active, unencumbered license may render an adverse determination regarding a service provided by a physician licensed in Florida;
- Shall give the subscriber the right to a second medical opinion in any instance in which the subscriber disputes the organization's or the physician's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness;
- Shall develop and maintain a policy to determine when exceptional referrals to out-of-network specially qualified providers should be provided to address the unique medical needs of a subscriber;
- Shall develop and maintain written policies and procedures for the provision of standing referrals to subscribers with chronic and disabling conditions which require ongoing specialty care;
- Shall allow subscribers undergoing active treatment to continue coverage and care when medically necessary, through completion of treatment of a condition for which the subscriber was receiving care at the time of the termination of a provider contract;
- Release specified data to the AHCA;
- Adopt recommendations for preventive pediatric health care which are consistent with the requirements for health checkups for children developed for the Medicaid program;
- Allow, without prior authorization, a female subscriber, to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary followup care; and

- Allow a contracted primary care physician to send a subscriber to a contracted licensed ophthalmologist under specified circumstances.

The bill provides that a person bringing an action for these violations of the HMO Act need not prove that the violation was committed with such frequency as to indicate a general business practice.

The bill provides that an HMO is liable for all of the claimant's damages or $500 per violation, whichever is greater, for violations of the above-cited statutes. The court may award damages, including damages for mental anguish, loss of dignity, and any other intangible injuries, and punitive damages.

Effective Date

The bill has an effective date of October 1, 2017.

Retroactivity

This bill provides that the repeal of s. 768.0981, F.S., and amendments to ss. 641.19, 641.51, and 641.3917, F.S., apply to causes of action accruing on or after October 1, 2017. The bill is not retroactive and does not apply to ongoing litigation or to causes of action accruing before October 1, 2017.

ERISA Preemption

Federal preemption may limit this bill's application in situations where an ERISA plan makes a decision to deny coverage. As discussed in *Davila* and subsequent cases, courts will have to review the facts of each case to determine whether preemption applies in cases related to coverage decisions. In addition to cases related to denial of coverage, courts have found ERISA preemption in cases related to a prompt pay law[21] and related to payment to medical providers.[22]

The provisions of the bill will apply to non-ERISA plans. It is not known how many persons covered under HMO plans are covered under plans that would be excluded from portions of this bill and how many persons are covered under plans that would be subject to all the provisions of the bill. A court noted that there is a trend in Georgia for employers to provide self-funded ERISA plans to their employees.[23] Subsequent to *Davila*, Texas passed a law to specifically exclude ERISA plans from the Texas Health Care Liability Act.[24] A 2005 bill analysis noted that there are only a few non-ERISA group health plans offered in Texas.[25]

[21] *America's Health Ins. v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014).
[22] *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc.*, 813 F.3d 1333 (11th Cir. 2015).
[23] *America's Health Ins. v. Hudgens*, 742 F.3d at 1324-1325.
[24] Texas Civil Practice and Remedies Code s. 88.0015.
[25] SB 554 Bill Analysis, Texas, March 17, 2005 (on file with the Committee on Banking and Insurance).

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 number of HMOs that will be affected by this bill and the extent that the bill will apply to each HMO is not known. Therefore, the fiscal impact of this bill is not known.

C. Government Sector Impact:

If there is an increase in litigation due to this bill, the state court system could see an increased workload.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 641.19, 641.51, and 641.3917.

This bill repeals section 768.0981 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 Steube

23-00399B-17 2017262__

A bill to be entitled

An act relating to health insurance; amending s. 641.19, F.S.; revising definitions; amending s. 641.51, F.S.; deleting a provision that provides that health maintenance organizations are not vicariously liable for certain medical negligence except under certain circumstances; amending s. 641.3917, F.S.; authorizing specified persons to bring a civil action against a health maintenance organization for certain violations; providing for construction; specifying a health maintenance organization's liability for such violations; repealing s. 768.0981, F.S., relating to a limitation on actions against insurers, prepaid limited health service organizations, health maintenance organizations, or prepaid health clinics; providing applicability; providing an effective date.

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

Section 1. Subsections (11), (12), and (18) of section 641.19, Florida Statutes, are amended to read:

641.19 Definitions.—As used in this part, the term:

(11) "Health maintenance contract" means any contract entered into by a health maintenance organization with a subscriber or group of subscribers to provide ~~coverage for~~ comprehensive health care services in exchange for a prepaid per capita or prepaid aggregate fixed sum.

(12) "Health maintenance organization" means any organization authorized under this part which:

(a) Provides~~, through arrangements with other persons,~~ emergency care~~;~~ inpatient hospital services~~;~~ physician care, including care provided by physicians licensed under chapters

23-00399B-17 2017262__

458, 459, 460, and 461~~;~~ ambulatory diagnostic treatment~~;~~ and preventive health care services.

(b) Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.

(c) Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract.

(d) Provides physician services, by physicians licensed under chapters 458, 459, 460, and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.

(e) If offering services through a managed care system, has a system in which a primary physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network.

~~Except in cases in which the health care provider is an employee of the health maintenance organization, the fact that the health~~

~~maintenance organization arranges for the provision of health care services under this chapter does not create an actual agency, apparent agency, or employer-employee relationship between the health care provider and the health maintenance organization for purposes of vicarious liability for the medical negligence of the health care provider.~~

(18) "Subscriber" means an entity or individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care services ~~coverage~~ or other persons who also receive health care services ~~coverage~~ as a result of the contract.

Section 2. Subsection (3) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.—

(3) The health maintenance organization shall not have the right to control the professional judgment of a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 concerning the proper course of treatment of a subscriber. However, this subsection shall not be considered to restrict a utilization management program established by an organization or to affect an organization's decision as to payment for covered services. ~~Except in cases in which the health care provider is an employee of the health maintenance organization, the health maintenance organization shall not be vicariously liable for the medical negligence of the health care provider, whether such claim is alleged under a theory of actual agency, apparent agency, or employer-employee relationship.~~

Section 3. Section 641.3917, Florida Statutes, is amended

to read:

641.3917 Civil liability.—

(1) The provisions of this part are cumulative to rights under the general civil and common law, and no action of the department or office shall abrogate such rights to damage or other relief in any court.

(2) Any person to whom a duty is owed may bring a civil action against a health maintenance organization when such person suffers damages as a result of the health maintenance organization's:

(a) Violation of s. 641.3155, s. 641.3903(5), (10), (12), (13), or (14), or s. 641.51; or

(b) Failure to provide a covered service, when the health maintenance organization in good faith should have provided such service had it acted fairly and reasonably toward the subscriber or enrollee and with due regard for his or her interests, and such service is medically reasonable or necessary in the independent medical judgment of a treating physician under contract with, or another physician authorized by, the health maintenance organization.

A person bringing an action under this subsection need not prove that such act was committed or performed with such frequency as to indicate a general business practice.

(3) The health maintenance organization is liable for all of the claimant's damages or $500 per violation, whichever is greater. The court may also award compensatory damages, including, but not limited to, damages for mental anguish, loss of dignity, and any other intangible injuries, and punitive

damages. In an action or proceeding brought under this subsection, the court shall award a prevailing plaintiff reasonable attorney fees as part of the costs.

Section 4. Section 768.0981, Florida Statutes, is repealed.

Section 5. The amendments to ss. 641.19, 641.51, and 641.3917, Florida Statutes, made by this act and the repeal of s. 768.0981, Florida Statutes, by this act apply to causes of action accruing on or after the effective date of this act.

Section 6. This act shall take effect October 1, 2017.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

SB 262
Bill Number (if applicable)

Topic Vicarious Liability

Amendment Barcode (if applicable)

Name Wences Troncoso

Job Title Vice President + General Counsel

Address 200 W. College Ave
Street

Phone 850-381-2004

City *State* *Zip*

Email

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

110 SOB
12:30 pm

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-21-2017
Meeting Date

SB 262 ✓
Bill Number (if applicable)

Topic HEALTH INSURANCE

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DR
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

262
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Tim Nungesser

Job Title Legislative Director

Address 110 E. Jefferson St.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-445-5367

Email tim.nungesser@nfib.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing National Federation of Independent Business

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/21/17 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 262

Meeting Date *Bill Number (if applicable)*

Topic managed care liability *Amendment Barcode (if applicable)*

Name Toni Large

Job Title

Address 519 E. Park Ave Phone (850) 556-1461

Street

Tallahassee FL 32308 Email toni@sulaw.net

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information Waive Speaking: ☒ In Support ☐ Against

(The Chair will read this information into the record.)

Representing Florida Orthopedic Society & Florida College of Emergency Physicians

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

SB 262
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Jeff Scott

Job Title _____

Address 6068 Wessex Ct.
Street

Tallahassee FL 32309
City *State* *Zip*

Phone 850 224-6496

Email jscott@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

262
Bill Number (if applicable)

Topic Vicarious Liability

Amendment Barcode (if applicable)

Name Chris Chaney

Job Title Lobbyist

Address 204 South Monroe Street
Street

Phone (850) 222-8900

Tallahassee FL 32301
City *State* *Zip*

Email cc@cardenaspartners.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

February 21, 2017
Meeting Date

SB 262
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name Paul P. Sanford

Job Title _____

Address 106 South Monroe Street
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-222-7200

Email paulsanf@aol.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Blue and Florida Insurance Council

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/2/17
Meeting Date

SB 262
Bill Number (if applicable)

Topic SB 262 - Villazon Bill

Amendment Barcode (if applicable)

Name Ted Leopold

Job Title Attorney

Address 2925 PGA BLVD
Street

Phone 561-575-1400

WPB FL 33410
City *State* *Zip*

Email TLeopold@CohenMilstein.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Patients Abused by Managed Care Companies

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/22/17
Meeting Date

742
Bill Number (if applicable)

Topic HEALTH INSUR

Amendment Barcode (if applicable)

Name GEORGE MEROS

Job Title ATTY

Address 301 S BRONOUGH
Street

TALLA FL
City *State* *Zip*

Phone 577-9890

Email GEORGE.MEROS@GRAY-ROBINSON.COM

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLA JUSTICE REFORM INST

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

262
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name Chris Nuland

Job Title _____

Address 1000 Riverside Ave #240
Street

Jacksonville FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

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 Simmons
SUBJECT:	Legislative Ratification
DATE:	February 20, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Knudson	BI	**Favorable**
2.			GO	
3.			RC	

I. Summary:

SB 404 exempts the adoption of workers' compensation maximum reimbursement allowances and manuals approved by a three-member panel from the legislative ratification requirement of s. 120.541(3), F.S.

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.[1] Rulemaking authority is delegated by the Legislature in law to an agency, and authorizes an agency to adopt, develop, establish, or otherwise create a rule.[2] An agency may not engage in rulemaking unless it has a legislative grant of authority to do so.[3] The statutory authority for rulemaking must be specific enough to guide an agency's rulemaking and an agency rule must not exceed the bounds of authority granted by the Legislature.[4]

Prior to the adoption, amendment, or repeal of any rule an agency must file a notice of the proposed rule in the Florida Administrative Register.[5] The notice of the proposed rule must include:

- An explanation of the purpose and effect;
- The specific legal authority for the rule;
- The full text of the rule; and

[1] Section 120.52(16), F.S.
[2] Section 120.52(17), F.S.
[3] *See* ss. 120.52(8) and 120.536(1), F.S.
[4] *See Sloban v. Florida Board of Pharmacy*, 982 So.2d 26 (Fla. 1st DCA 2008) and *Southwest Florida Water Management District v. Save the Manatee Club, Inc*., 773 So.2d 594 (Fla 1st DCA 2000).
[5] *See* ss. 120.54(2)(a) and 120.55(1)(b), F.S.

- A summary of the agency's SERC, if one is prepared.[6]

Within 21 days of the notice, the public may provide an agency with information regarding the SERC or provide proposals for a lower cost alternative to the rule.[7]

SERC Requirements

Agencies must prepare the SERC for a rule that has an adverse impact on small businesses or that increases regulatory costs more than $200,000 within 1 year after implementation of the rule.[8]

A SERC must include estimates of:
- The number of people and entities effected by the proposed rule;
- The cost to the agency and other governmental entities to implement the proposed rule;
- Transactional costs likely to be incurred by people, entities, and governmental agencies for compliance; and
- An analysis of the proposed rule's impact on small businesses, counties, and cities.[9]

The SERC must also include an economic analysis on the likelihood that the proposed rule will have an adverse impact in excess of $1 million within the first 5 years of implementation on:
- Economic growth, private-sector job creation or employment, or private-sector investment;
- Business competitiveness,[10] productivity, or innovation; or
- Regulatory costs, including any transactional costs.[11]

If the economic analysis results in an adverse impact or regulatory costs in excess of $1 million within 5 years after implementation of the rule, then the Legislature must ratify the rule in order for it to take effect.[12]

Workers' Compensation Maximum Reimbursement Allowances

The Department of Financial Services (DFS), Division of Workers' Compensation, provides regulatory oversight of Florida's workers' compensation system. Florida's workers' compensation law provides medically necessary treatment and care for injured employees, including medications. The law provides reimbursement formulas and methodologies to compensate providers of health services, subject to maximum reimbursement allowances (MRAs).

[6] Section 120.54(3)(a)1., F.S.
[7] *See* ss. 120.54(3)(a)1., and 120.541(1)(a), F.S.
[8] Section 120.541(1)(a), F.S.
[9] Section 120.541(2)(b)-(e), F.S. A small city has an unincarcerated population of 10,000 or less. A small county has an unincarcerated population of 75,000 or less. A small business employs less than 200 people, and has a net worth of $5 million or less.
[10] Business competitiveness includes the ability of those doing business in Florida to compete with those doing business in other states or domestic markets.
[11] Section 120.541(2)(a), F.S.
[12] Section 120.541(3), F.S. Legislative ratification is not required for adoption of federal standards, amendments to the Florida Building Code, or amendments to the Florida Fire Prevention Code. *See* s. 120.541(4), F.S.

A three-member panel (panel) consisting of the CFO or CFO's designee and two Governor's appointees sets the MRAs.[13] The DFS incorporates the statewide schedules of the MRAs by rule in reimbursement manuals. In establishing the MRA manuals, the panel considers the usual and customary levels of reimbursement for treatment, services, and care;[14] the cost impact to employers for providing reimbursement that ensures that injured workers have access to necessary medical care;[15] the financial impact of the MRAs on health care providers and facilities;[16] and the Health Care Board's most recent maximum allowable rate of increase for hospitals.[17] Florida law requires the panel to develop MRA manuals that are reasonable, promote the workers' compensation system's health care cost containment and efficiency, and are sufficient to ensure that medically necessary treatment is available for injured workers.[18]

The panel develops four different reimbursement manuals to determine statewide schedules of maximum reimbursement allowances. The healthcare provider manual limits the maximum reimbursement for licensed physicians to 110 percent of Medicare reimbursement,[19] while reimbursement for surgical procedures is limited to 140 percent of Medicare.[20] The hospital manual sets maximum reimbursement for outpatient scheduled surgeries at 60 percent of usual and customary charges,[21] while other outpatient services are limited to 75 percent of usual and customary charges.[22] Reimbursement of inpatient hospital care is limited based on a schedule of per diem rates approved by the panel.[23] The ambulatory surgical centers manual limits reimbursement to 60 percent of usual and customary as such services are generally scheduled outpatient surgeries. The prescription drug reimbursement manual limits reimbursement to the average wholesale price plus a $4.18 dispensing fee.[24] Repackaged or relabeled prescription medication dispensed by a dispensing practitioner has a maximum reimbursement of 112.5 percent of the average wholesale price plus an $8.00 dispensing fee.[25]

The 2016 Legislature ratified Rule 69L-7.020, F.A.C., which incorporates by reference the Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2015 Edition, (manual) providing for reimbursement of health care providers under the increased MRAs approved by the panel. According to the Statement of Estimated Regulatory Costs (SERC), the revisions to MRAs in the updated manual were projected to result in increased costs to the overall compensation system of $272 million over the next 5 years.[26]

[13] Section 440.13(12)(d)4., F.S.
[14] Section 440.13(12)(d)1., F.S.
[15] Section 440.13(12)(d)2., F.S.
[16] Section 440.13(12)(d)3., F.S.
[17] Section 440.13(12)(d)4., F.S.
[18] Section 440.13(12)(d)3., F.S.
[19] Section 440.13(12)(b)4., F.S.
[20] Section 440.13(12)(b)5., F.S.
[21] Section 440.13(12)(b)3., F.S.
[22] Section 440.13(12)(a), F.S.
[23] Section 440.13(12)(a), F.S.
[24] Section 440.13(12)(c), F.S.
[25] See Id.
[26] Department of Financial Services Statement of Estimated Regulatory Costs, Workers' Compensation, *Rule 69L-7.020, F.A.C., Florida's Workers' Compensation Health Care Provider Reimbursement Manual* (on file with the Senate Committee on Banking and Insurance).

The DFS has subsequently adopted amended versions of Rule 69L-7.501, F.A.C., incorporating by reference the 2016 Edition of the Manual for Hospitals and Rule 97L-7.100, incorporating by reference the 2016 Edition of the Manual for Ambulatory Surgical Centers. The rules also update incorporating references to other materials used for provider reimbursement together with the manual. The National Council on Compensation Insurance estimates that the 2016 hospital manual will increase workers' compensation system costs by 2.2 percent ($80 million) and that the 2016 ambulatory surgical center manual will increase workers' compensation system costs by 0.6 percent ($22 million). The rules incorporating these manuals will not become effective unless ratified by the Legislature pursuant to s. 120.541(3), F.S., or this bill exempting the adoption of workers' compensation maximum reimbursement allowances and manuals approved by the three-member panel becomes law.

III. Effect of Proposed Changes:

The bill exempts the adoption of workers' compensation maximum reimbursement allowances and manuals approved by a three-member panel from the legislative ratification requirement of section 120.541(3), F.S.

The effective date is July 1, 2017.

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 National Council on Compensation Insurance, Inc. (NCCI) estimates implementing the 2016 edition of the ambulatory surgical center reimbursement manual will increase workers' compensation costs by $22 million.[27] The NCCI also estimates that

[27] National Council on Compensation Insurance, Inc., *Analysis of Proposed Changes to the Florida ASC Maximum Reimbursements Proposed to be Effective July 1, 2017*, April 13, 2016 (on file with the Senate Committee on Banking and Insurance).

implementing the 2016 Edition of the Hospital Reimbursement Manual will increase overall workers' compensation costs by $80 million.[28]

C. Government Sector Impact:

The Department of Financial Services estimates that adoption of the hospital reimbursement manual and the ambulatory surgical center reimbursement manual will have the following financial impact on the workers' compensation expenses of the Department of Risk Management:[29]

- Hospital reimbursement manual:
  - Fiscal year 2017-18 = $2,356,502
  - Fiscal year 2018-19 = $2,437,902
  - Fiscal year 2019-20 = $2,517,102
- Ambulatory surgical center reimbursement manual:
  - Fiscal year 2017-18 = $642,682
  - Fiscal year 2018-19 = $664,882
  - Fiscal year 2019-20 = $686,482

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 120.80 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.

[28] National Council on Compensation Insurance, Inc., *Analysis of Proposed Changes to the Florida Reimbursement Manual for Hospitals Proposed to be Effective July 1, 2017*, April 14, 2016 (on file with the Senate Committee on Banking and Insurance).
[29] Florida Department of Financial Services, *Analysis of SB 404 to the Senate Budget Committee*, February 7, 2017 (on file with the Senate Committee on Banking and Insurance).

By Senator Simmons

9-00490-17 2017404__

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 when the adverse impact or regulatory costs of such allowances or manuals exceed any criteria specified in s. 120.541(2)(a), F.S.; providing an effective date.

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

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, 2017.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-21-17
Meeting Date

SB 404
Bill Number (if applicable)

Topic Legislative ratification / SB 404

Amendment Barcode (if applicable)

Name Elizabeth Boyd

Job Title Legislative Affairs Director

Address 400 N Monroe St
Street

Phone 413-2863

Tallahassee FL 32399
City *State* *Zip*

Email elizabeth.boyde@myflsenate.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing CFO Atwater

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

Feb. 21, '17 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 404

Meeting Date *Bill Number (if applicable)*

Topic Workers' Comp Ratification *Amendment Barcode (if applicable)*

Name Toni Large

Job Title

Address 519 E. Park Ave Phone (850) 556-1461

Street

Tallahassee, FL 32308 Email toni@sulaw.net

City *State* *Zip*

Speaking: ~~For~~ ☐ Against ☐ Information Waive Speaking: ☑ In Support ☐ Against

(The Chair will read this information into the record.)

Representing Florida Orthopedic Society

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

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:	CS/SB 420
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Flood Insurance
DATE:	February 21, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Fav/CS**
2.			CA	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 420 extends to October 1, 2025, existing law that allows insurers offering private market flood insurance under s. 627.715, F.S., to make rate filings that are not required to be reviewed by the Office of Insurance Regulation (OIR) before implementation of the rate ("file and use" review) or shortly after implementation of the rate ("use and file" review). The bill generally applies s. 627.715, F.S., to excess flood insurance. Excess coverage is exempted from the requirement of s. 627.715(1), F.S., to offer flood insurance on a standard, preferred, customized, flexible, or supplemental basis. The bill allows flood policies to be placed with a surplus lines insurer with a superior financial strength rating without the agent first receiving three declinations from admitted insurers. The bill increases the interval for the Florida Commission on Hurricane Loss Projection Methodology to revise the criteria used in calculating flood loss projection models to 4 years. Lastly, the bill requires an insured currently covered under the National Flood Insurance Program to sign an acknowledgement regarding the risk of being charged a higher rate should they choose to return at a later date.

II. Present Situation:

In 2014, the Legislature passed CS/CS/CS/SB 542, allowing an expedited process for insurers to offer a variety of private flood insurance policies. The bill created s. 627.715, F.S., governing the sale of personal lines, residential flood insurance. The statute does not apply to commercial lines residential, commercial lines nonresidential, or excess flood insurance. Under this new section, authorized insurers can sell five different types of flood insurance products:

- Standard coverage, which covers only losses from the peril of flood as defined 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.[1]
- 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, coverage for additional living expenses, and replacement cost coverage for personal property or contents coverage.[2]
- Customized coverage, which is coverage that is broader than standard flood coverage.[3]
- Flexible coverage, which has coverage limits at an agreed upon amount, deductibles ranging from $500 to 10 percent of policy dwelling limits, adjusts dwelling losses on the basis of actual cash value or pursuant to s. 627.7011(3), F.S., restricts coverage to the principal building defined in the policy, excludes additional living expenses coverage, or excludes personal property or contents coverage.[4]
- 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.[5]

The law requires 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 National Flood Insurance Program.[6]

Under the law an insurer may establish flood rates through the standard process in s. 627.062, F.S. Alternatively, rates filed before October 1, 2019,[7] 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 OIR 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.

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.[8]

[1] s. 627.715(1)(a)1., F.S.
[2] s. 627.715(1)(a)2., F.S.
[3] s. 627.715(1)(a)3., F.S.
[4] s. 627.715(1)(a)4., F.S.
[5] s. 627.715(1)(a)5., F.S.
[6] s. 627.715(8), F.S.
[7] s. 627.715(3)(b), F.S.
[8] s. 627.715(5), F.S.

The law allows surplus lines agents to export flood insurance without making a diligent effort to seek coverage from three or more authorized insurers until July 1, 2017.[9] The law prohibits Citizens Property Insurance Corporation from providing flood insurance.[10] The law prohibits the Florida Hurricane Catastrophe Fund from reimbursing flood losses.[11] The law allows projected flood losses for personal residential property insurance to be a rating factor. Flood losses may be estimated using a model or straight average of models found reliable by the Florida Commission on Hurricane Loss Projection Methodology.[12]

The law also specifies that the OIR Commissioner may provide a certification required by federal law or rule as a condition of qualifying for private flood insurance or disaster assistance. The certification is not subject to review under ch. 120, F.S.[13]

The National Flood Insurance Program (NFIP)

The NFIP was created by the passage of the National Flood Insurance Act of 1968.[14] The NFIP is administered by 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.[15]

Florida Commission on Hurricane Loss Projection Methodology (Commission)

In 1995 the Legislature established the Commission to serve as an independent body within the State Board of Administration.[16] Section 627.0628, F.S., lists the 12 members who are to make up the Commission. The Commission is to adopt findings on the accuracy or reliability of the methods, standards, principles, models and other means used to project hurricane and flood losses. The Commission sets standards for loss projection methodology and examines the methods employed in proprietary loss models used by private insurers in setting rates to determine whether they meet the Commission's standards. The law requires the Commission to revise previously adopted actuarial methods, principles, standards, models, or output ranges every odd numbered year.[17]

III. Effect of Proposed Changes:

The bill requires the Florida Commission on Hurricane Loss Projection Methodology to revise previously adopted actuarial methods, principles, standards, models, or output ranges no less than every 4 years for flood loss projections. Existing law requires revisions no less than every 2 years.

[9] s. 627.715(4), F.S.
[10] s. 627.715(6), F.S.
[11] s. 627.715(7), F.S.
[12] s. 627.062(2)(b)12, F.S.
[13] s. 627.715(10), F.S.
[14] http://www.fema.gov/media-library/assets/documents/7277?id=2216 (Last accessed February 17, 2017).
[15] https://www.fema.gov/media-library-data/20130726-1545-20490-9247/frm_acts.pdf (Last accessed February 17, 2017).
[16] s. 627.0628, F.S.
[17] s. 627.0628(3)(f), F.S.

The bill extends from October 1, 2019, to October 1, 2025, the time period during which personal lines residential flood insurance rates 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). The expedited filing also applies to commercial and commercial residential policies. After 2025, insurers offering private flood insurance will be required to make a complete rate filing with the OIR as required under s. 627.062, F.S.

The bill generally applies s. 627.715, F.S., to excess flood insurance and exempts such coverage for s. 627.715(5), F.S. Excess coverage is exempted from the requirement of s. 627.715(1), F.S., to offer flood insurance on a standard, preferred, customized, flexible, or supplemental basis. Excess coverage generally covers gaps above the NFIP limits and can also be purchased to cover gaps in private flood coverage.

The bill allows flood policies to be placed with a surplus lines insurer with a superior financial strength rating without the agent first receiving three declinations from admitted insurers.

The bill prohibits a policy from being removed from the NFIP if the policyholder does not sign an acknowledgment within 20 days of their current policy expiring. The acknowledgment provides a warning of the potential rate increase should they choose to return to the NFIP at a later date. A policy must be returned to the NFIP if the assigned agent does not receive this signed acknowledgment from the policyholder.

The bill makes a technical correction that clarifies insurers can offer a flexible flood insurance policy as defined in s. 627.715(1)(a)4., F.S.

The effective date of the bill is July 1, 2017.

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:

Insurers can now offer excess flood insurance under s. 627.715, F.S.

The bill requires surplus lines insurers to maintain a superior, excellent, exceptional or equivalent financial strength rating by a rating agency acceptable to the Office before issuing a private flood insurance policy without obtaining three declinations from admitted insurers.

C. None. 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: 627.0628, 627.715.

IX. Additional Information:

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

CS by Banking and Insurance on February 21, 2017:

- The CS includes excess coverage for the peril of flood under s. 627.715, F.S.
- The CS allows flood insurance to be placed with an eligible surplus lines insurer without making a diligent effort to seek coverage from 3 or more Florida-licensed insurers if the surplus lines insurer has a superior, excellent, exceptional or equivalent financial strength rating by a rating agency acceptable to the Office.

B. Amendments:

None.

676588

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
02/21/2017	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 148 - 150

and insert:

626.916(1) if the surplus lines insurer maintains a superior, excellent, exceptional, or equivalent financial strength rating by a rating agency acceptable to the office ~~s. 626.916(1)(a). This subsection expires July 1, 2017~~.

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

676588

And the title is amended as follows:

Delete line 16

and insert:

or endorsements to the insurer; deleting the

670196

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/21/2017	.	
	.	
	.	
	.	

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

Senate Substitute for Amendment (676588) (with title amendment)

Delete lines 148 - 152
and insert:
626.916(1) if the surplus lines insurer maintains a superior, excellent, exceptional, or equivalent financial strength rating by a rating agency acceptable to the office ~~s. 626.916(1)(a). This subsection expires July 1, 2017~~.
(5) In addition to any other applicable requirements, an

670196

insurer providing flood coverage that is not excess coverage in this state must:

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

And the title is amended as follows:

Delete lines 16 - 17

and insert:

or endorsements to the insurer; deleting the expiration date of the exception; revising applicability of certain notification and filing requirements; revising provisions

283966

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/21/2017	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 41 - 94

and insert:

lines residential coverage for the peril of flood or excess 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~~

283966

~~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, flexible, or supplemental basis.

(1)(a) Except for excess flood insurance policies, policies issued under this section include:

1. Standard flood insurance, which 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, which 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, which must include coverage that is broader than the coverage provided under standard flood insurance.

4. Flexible flood insurance, which must cover losses from the peril of flood, as defined in paragraph (b), and may also

283966

include coverage for losses from water intrusion originating 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.

5. Supplemental flood insurance, which 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 line 7

and insert:

amending s. 627.715, F.S.; authorizing certain insurers to issue insurance policies, contracts, or endorsements providing certain excess coverage for the

283966

peril of flood; revising applicability;

By Senator Brandes

24-00096D-17 2017420__

A bill to be entitled

An act relating to flood insurance; amending s. 627.0628, F.S.; revising the intervals at which specified standards and guidelines for projecting certain rate filings must be revised by the Florida Commission on Hurricane Loss Projection Methodology; amending s. 627.715, F.S.; revising applicability; authorizing an insurer to issue flood insurance policies on a flexible basis; extending the last date of filing with the Office of Insurance Regulation of certain flood coverage rates that may be established and used by an insurer; specifying a condition for an eligible surplus lines insurer before a surplus lines agent may be excepted from a diligent-effort requirement when exporting flood insurance contracts or endorsements to the insurer; extending the expiration date of the exception; revising provisions related to an acknowledgment required before the procurement of a private flood insurance policy for property currently insured under the National Flood Insurance Program; providing an effective date.

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

Section 1. Paragraph (f) of subsection (3) of section 627.0628, Florida Statutes, is amended to read:

627.0628 Florida Commission on Hurricane Loss Projection Methodology; public records exemption; public meetings exemption.—

(3) ADOPTION AND EFFECT OF STANDARDS AND GUIDELINES.—

(f) The commission shall revise previously adopted actuarial methods, principles, standards, models, or output

24-00096D-17 2017420__

ranges every odd-numbered year for hurricane loss projections. The commission shall revise previously adopted actuarial methods, principles, standards, models, or output ranges no less than every 4 years for flood loss projections.

Section 2. 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. Except for subsections (3) and (4), 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, flexible, 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 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 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.

5. 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.

(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) Flood coverage deductibles and policy limits pursuant to this section 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, 2025 ~~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. 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 or an appropriate refund to affected insureds who no longer receive coverage from the insurer.

(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) if the surplus lines insurer maintains a minimum of

$300 million in capital and surplus ~~s. 626.916(1)(a)~~. This subsection expires July 1, 2025 ~~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) When procuring a private flood insurance policy from an authorized insurer or a surplus lines insurer for a property that is currently insured under the National Flood Insurance Program, an agent must receive an acknowledgment signed by the applicant within 20 days before the expiration date of the current coverage. The acknowledgment must notify the applicant that the full risk rate for flood insurance may apply to the property if such insurance is later obtained under the National Flood Insurance Program. If the agent does not receive the acknowledgment, the private flood insurance policy must be canceled and the premium must be remitted to a participant in the National Flood Insurance Program ~~An agent must, upon receiving an application for flood coverage from an authorized or surplus lines insurer for a property receiving flood insurance under the National Flood Insurance Program, 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 later seeks to reinstate coverage under the 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)(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 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.

Section 3. This act shall take effect July 1, 2017.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

420
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name JACQUELINE NOTO

Job Title PRODUCT MANAGER

Address _____ Phone 201.673.4521
Street

Email jackie.noto@rms.com

City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing RISK MANAGEMENT SOLUTIONS

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/17
Meeting Date

420
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Michael Yuns

Job Title Senior Director

Address _____ Phone _____
Street

_____ Email michael.yuns@rms.com
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing RMS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

CourtSmart Tag Report

Room: EL 110 **Case No.:** **Type:**
Caption: Senate Committee Banking and Insurance **Judge:**

Started: 2/21/2017 12:36:21 PM
Ends: 2/21/2017 1:29:56 PM Length: 00:53:36

12:36:35 PM	Roll call - quorum present
12:37:14 PM	Tab 4 - SB 420
12:38:14 PM	Senator Brandes recognized to present the b ill
12:39:02 PM	Substitute amendment taken up - fwo - adopted
12:39:50 PM	Amd. 283933 adopted fwo
12:42:32 PM	Vote on CS/SB 420 --Favorable
12:43:44 PM	TAB 2 - SB 262
12:44:17 PM	Senator Steube recognized to explain the bill
12:49:55 PM	George Meros, FL Justice Reform Institute
12:50:56 PM	SB 262 TP's w/o
12:51:09 PM	TAB 3 - SB 404 by Senator Simmons
12:51:48 PM	Vote on SB 404 -Favorable
12:52:19 PM	Back on SB 262
1:01:18 PM	Wences Troncoso, FL Association of Health Plans
1:03:09 PM	Paul Sanford, Florida Blue and Florida Insurance Council
1:04:09 PM	Motion to TP SB 252
1:04:22 PM	TAB 1 - SB 102 - Explanation of bill by Sen. Steube
1:07:05 PM	Wences Troncoso, FL Association of Health Plans
1:08:06 PM	Chris Hansen, FL Podiatric Medical Association
1:12:28 PM	Dr. Paul Bruning, FL Orthopedic /FL Medical Association
1:14:11 PM	Paul Sanford - Fl Blue and FL Insurance Council
1:16:54 PM	Final Vote on SB 102 -- Favorable
1:20:37 PM	Motion to take up SB 262
1:21:44 PM	Ted Leopold-Patients Abused by Managed Care Companies
1:28:40 PM	Senator Steube closed on bill/meeting adjourned