The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Tuesday, March 29, 2011
TIME: 1:00 —3:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Richter, Chair; Senator Smith, Vice Chair; Senators Alexander, Bennett, Bogdanoff, Fasano, Hays, Margolis, Negron, Oelrich, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**CS/SB 670** Judiciary / Joyner (Similar CS/H 815)	Powers of Attorney; Provides for a durable power of attorney. Specifies the qualifications for an agent. Provides requirements for the execution of a power of attorney. Provides for the validity of powers of attorney created by a certain date or in another jurisdiction. Provides for the validity of a military power of attorney. Provides for the validity of a photocopy or electronic copy of a power of attorney. Provides for the meaning and effectiveness of a power of attorney, etc. JU 03/14/2011 Fav/CS BI 03/29/2011 RC	
2	**SB 100** Ring (Identical H 1431)	Autism; Requires that a physician refer a minor to an appropriate specialist for screening for autism spectrum disorder under certain circumstances. Requires that certain insurers and health maintenance organizations provide direct patient access to an appropriate specialist for screening for or evaluation or diagnosis of autism spectrum disorder, etc. HR 03/22/2011 Favorable BI 03/29/2011 BC	
3	**SB 1930** Bogdanoff (Compare CS/H 967, H 1411, S 1694)	Motor Vehicle Personal Injury Protection Insurance; Revises provisions relating to the contents of written reports of motor vehicle crashes. Requires that an application for licensure as a mobile clinic include a statement regarding insurance fraud. Authorizes the Division of Insurance Fraud to establish a direct-support organization for the purpose of prosecuting, investigating, and preventing motor vehicle insurance fraud. Requires a claimant's request about insurance coverage to be appropriately served upon the disclosing entity, etc. BI 03/29/2011 CJ BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1826** Hays (Identical H 4083, Compare H 4073)	Workers' Compensation; Repeals provisions relating to the Workers' Compensation Administrator, to abolish the position. Deletes an obsolete transitional requirement for certain policies of the Florida Workers' Compensation Joint Underwriting Association. BI 03/29/2011 BC	
5	**SB 1714** Hays (Identical H 1243)	Citizens Property Insurance Corporation; Provides that certain residential structures are not eligible for coverage by the corporation after a certain date. Requires policies issued by the corporation to include a provision that prohibits policyholders from engaging the services of a public adjuster. Prohibits the corporation from levying certain assessments with respect to a year's deficit until the corporation has first levied a specified surcharge. Requires owners of properties in Special Flood Hazard Areas to maintain a separate flood insurance policy after a certain date, etc. BI 03/29/2011 BC	
6	**SB 1694** Richter (Compare CS/H 967, H 1411, S 1930)	Motor Vehicle Personal Injury Protection Insurance; Provides that the circuit court has exclusive jurisdiction in actions involving challenges to arbitration decisions under the Florida Motor Vehicle No-Fault Law. Requires a claimant's request about insurance coverage to be appropriately served upon the disclosing entity. Provides that an insurer that requests an examination under oath in a manner that is inconsistent with the policy is engaging in an unfair and deceptive trade practice, etc. BI 03/29/2011 JU BC	
7	**SB 1806** Diaz de la Portilla (Identical H 1439)	Motor Vehicle Insurance; Revises provisions relating to proof of financial responsibility for rented or leased motor vehicles. Provides lessors and lessees of rented and leased motor vehicles with certain responsibilities relating to the provision and obtaining of liability insurance. Revises who is deemed the owner of a motor vehicle for purposes of determining financial responsibility. Revises applicability of certain provisions relating to financial responsibility of an owner of commercial motor vehicles. BI 03/29/2011 JU TR BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 1500** Latvala (Identical H 1019, Compare S 1972)	Foster Care Providers; Decreases the limits of liability and requisite insurance coverage for lead community-based providers and subcontractors. Provides immunity from liability for the Department of Children and Family Services for acts or omissions of a community-based provider or subcontractor, or the officers, agents, or employees thereof. BI 03/29/2011 CF JU BC	

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 Judiciary Committee

BILL:	CS/SB 670
INTRODUCER:	Judiciary Committee and Senator Joyner
SUBJECT:	Powers of Attorney
DATE:	March 27, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Maclure	JU	**Fav/CS**
2.	Arzillo	Burgess	BI	**Pre-meeting**
3.			RC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill seeks to conform Florida's power of attorney law under chapter 709, Florida Statutes, to the Uniform Power of Attorney Act,[1] with some modifications to achieve greater consistency among state laws.

The bill creates part I of ch. 709, F.S., consisting of ss. 709.02-709.07, F.S., titled "Powers of Appointment." The bill creates part II of ch. 709, F.S., consisting of ss. 709.2101-709.2402, F.S., titled "Powers of Attorney."

The revised power of attorney law applies only to powers of attorney created by an individual. Powers of attorney validly executed under Florida law before the effective date this bill will remain valid. If the power of attorney is durable[2] or springing,[3] it will remain durable or springing under the new law. To be effective in Florida, powers created on or after the effective date of this bill must be exercisable as of the time they are executed. The meaning and

[1] *See* National Conference of Commissioners on Uniform State Laws, A Few Facts About the Uniform Power of Attorney Act, http://www.nccusl.org/Act.aspx?title=Power%20of%20Attorney (last visited Mar. 9, 2011).
[2] Power of attorney which is not terminated by the principal's incapacity.
[3] Power of attorney which does not take effect until the principal loses capacity.

effectiveness of a power of attorney is governed by part II of ch.709, F.S. A power of attorney executed in another state that does not comply with the execution requirement of this part (part II of ch. 709, F.S.) is valid in Florida only if the execution of the power of attorney complied with the law of the state of execution.

Powers of attorney that are executed after the effective date of part II of ch. 709, F.S., may not create springing powers, with an exception for military powers. Qualified agents as defined in the bill are entitled to reasonable compensation. The revised power of attorney provides requirements for written notice with special notice for financial institutions, and special rules for banking and investment transactions; provides default duties for the agent; creates co-agents and successor agents; prohibits blanket or default powers granted to an agent; prescribes requirements for the rejection by a third person of power of attorney; prescribes requirements for an agent's liability under power of attorney; and provides grounds for judicial relief and dealing with conflicts of interest.

This bill creates the following sections of the Florida Statutes: 709.2101, 709.2102, 709.2103, 709.2104, 709.2105, 709.2106, 709.2107, 709.2108, 709.2109, 709.2110, 709.2111, 709.2112, 709.2113, 709.2114, 709.2115, 709.2116, 709.2117, 709.2118, 709.2119, 709.2120, 709.2121, 709.2201, 709.2202, 709.2208, 709.2301, 709.2302, 709.2303, 709.2401, and 709.2402.

The bill amends section 736.0602, Florida Statutes. The bill repeals the following sections of the Florida Statutes: 709.01, 709.015, 709.08, and 709.11.

II. Present Situation:

A power of attorney is a legal document that delegates authority from one person to another.[4] The person who creates a power of attorney is the principal, and the person to whom the authority to act is delegated is an agent of the principal. The power of attorney is an important document because it allows one person to legally act for another, and it benefits and binds the principal as if the principal had done the act himself or herself. A durable power of attorney is power of attorney that continues to be legally effective if the principal becomes incapacitated.[5] Durable powers of attorney are often used in estate planning as an alternative to guardianship if a principal becomes incapacitated.[6]

In 2006, the Uniform Law Commission of the National Conference of Commissioners on Uniform State Laws completed a Uniform Power of Attorney Act.[7] Since that time, nine states (Colorado, Idaho, Indiana, Maine, Maryland, Nevada, New Mexico, Virginia, and Wisconsin) and one United States territory (U.S. Virgin Islands) have adopted the Uniform Power of Attorney Act.[8]

[4] *See* ch. 709, F.S.
[5] *See* s. 709.08, F.S.
[6] Real Property, Probate and Trust Law Section of the Florida Bar, White Paper: Chapter 709, F.S. (2011) (on file with the Senate Committee on Judiciary).
[7] See National Conference of Commissioners on Uniform State Laws, *supra* note 1.
[8] *Id.*

A committee was formed in Florida to evaluate the Uniform Power of Attorney Act for possible enactment in Florida.[9] The committee included attorneys with practices in various disciplines, including estate planning, estate and trust litigation, elder law, and family law, and attorneys who work for financial institutions, who represent the Florida Bankers Association and attorneys whose practice is comprised of real estate title insurance.[10] The committee recommended significant revisions to ch. 709, F.S., to propose the creation of a new part I to reinstate without substantive change those current provisions of ch. 709, F.S., relating to "powers of appointment" and a new part II of ch. 709, F.S., relating to "powers of attorney."[11]

III. Effect of Proposed Changes:

The bill seeks to conform Florida's power of attorney law under ch. 709, F.S., to the Uniform Power of Attorney Act, with some modifications to achieve greater consistency among state laws. The bill creates part I of ch. 709, F.S., consisting of ss. 709.02-709.07, F.S., titled "Powers of Appointment." The bill creates part II of ch. 709, F.S., consisting of ss. 709.2101-709.2402, F.S., titled "Powers of Attorney."

The revised power of attorney law applies only to powers of attorney created by an individual. Powers of attorney validly executed under Florida law before the effective date of the new Florida powers of attorney law will remain valid. If the power of attorney is durable[12] or springing,[13] it will remain durable or springing under the new law. To be effective in Florida, powers created on or after the effective date of the new power of attorney law must be exercisable as of the time they are executed. The meaning and effectiveness of a power of attorney is governed by part II of ch. 709, F.S., if the power of attorney is used in Florida or states that it is to be governed by Florida law. A power of attorney executed in another state that does not comply with the execution requirement of this part (part II of ch. 709, F.S.) is valid in Florida if the execution of the power of attorney complied with the law of the state of execution.[14] The revised power of attorney law provides: requirements for written notice with special notice for financial institutions; special rules for banking and investment transactions; and default duties for the agent. The revised power of attorney law: creates co-agents and successor agents; prohibits blanket or default powers granted to an agent; outlines requirements for the rejection by a third person of power of attorney; specifies requirements for an agent's liability under power of attorney; and provides grounds for judicial relief and dealing with conflicts of interest.

Section-by-Section Analysis

Section 1 creates part I of ch. 709, F.S., consisting of ss. 709.02-709.07, F.S., titled "Powers of Appointment."

[9] Real Property, Probate and Trust Law Section of the Florida Bar, *supra* note 4.
[10] *Id.*
[11] *Id.*
[12] *See* note 2.
[13] *See* note 3.
[14] This concept of portability makes powers of attorney portable between states. See Real Property, Probate and Trust Law Section of the Florida Bar, *supra* note 4.

Section 2 creates part II of ch. 709, F.S., consisting of ss. 709.2101-709.2402, F.S., titled "Powers of Attorney."

Section 3 creates s. 709.2101, F.S., which provides for the "Florida Power of Attorney Act."

Section 4 creates s. 709.2102, F.S., which provides definitions.

"Agent" means a person granted authority to act for a principal under a power of attorney, whether denominated an agent, attorney-in-fact, or otherwise, and the term includes an original agent, co-agent, and successor agent.

"Durable" means, with respect to a power of attorney, not terminated by the principal's incapacity.

"Electronic" means technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

"Financial institution" has the same meaning as in s. 655.005, F.S., relating financial institutions.

"Incapacity" means the inability of an individual to take those actions necessary to obtain, administer, and dispose of real and personal property, intangible property, business property, benefits, and income.[15]

"Knowledge" means a person has actual knowledge of the fact, has received a notice or notification of the fact, or has reason to know the fact from all other facts and circumstances known to the person at the time in question. With respect to an organization operating through employees, the organization has notice of or knowledge of a fact involving the power of attorney only from the earlier of the time the information was received by an employee having responsibility to act on matters involving the power of attorney or the time the information would have been brought to the employee's attention if the organization had exercised reasonable diligence. The term is substantively identical to the definition of the term in the Florida Probate Code.[16]

"Power of Attorney" means a writing that grants authority to an agent to act in the place of the principal, whether or not that the term is used in the writing. An act performed by an agent pursuant to a power of attorney has the same effect and benefit to the principal and the principal's successors in interest as if the principal had performed the act.

"Principal" means an individual who grants authority to an agent in a power of attorney.

"Sign" means having present intent to authenticate or adopt a record to: execute or adopt a tangible symbol; or attach to, or logically associate with the record an electronic sound, symbol, or process.

[15] See s. 744.102(12)(a), F.S., which provides a comparable definition for an "incapacitated person" as it relates to the management of property.
[16] See s. 736.0104, F.S.

"Third person" means any person other than the principal or the agent in the agent's capacity as agent.

Section 5 creates s. 709.2103, F.S., which provides that this part (part II of ch. 709, F.S.) applies to all powers of attorney except:

- A proxy or other delegation to exercise voting rights or management rights with respect to an entity;
- A power created on a form prescribed by a government or its subdivision for a governmental purpose;
- A power to the extent it is coupled with an interest in the subject of the power, including a power given to or for the benefit of a creditor in connection with a credit transaction; and
- A power created by a person other than an individual.

Section 6 creates s. 709.2104, F.S., which provides that except as otherwise provided under this part (part II of ch. 709, F.S.), a power of attorney is durable if it contains the words: "This durable power of attorney is not terminated by subsequent incapacity of the principal except as provided in chapter 709, Florida Statutes," or similar words that show the principal's intent that the authority conferred is exercisable notwithstanding the principal's subsequent incapacity.

Section 7 creates s. 709.2105, F.S., which specifies qualifications of the agent and requirements for the execution of a power of attorney. The agent must be a natural person who is 18 years of age or older or a financial institution that has trust powers, has a place of business in Florida, and is authorized to conduct trust business in Florida.

A power of attorney must be signed by the principal and by two subscribing witnesses and be acknowledged by the principal before a notary public or otherwise provided for the conveyance of real estate.[17]

Section 8 creates s. 709.2106, F.S., which specifies that a power of attorney executed on or after October 1, 2011, is valid if its execution complies with s. 709.2105, F.S. A power of attorney executed before October 1, 2011 is valid if its execution complied with Florida law at the time of execution. Additionally, if the power of attorney is a durable power of attorney or a springing power of attorney, it will remain durable or springing under this act (part II of ch. 709, F.S.).

A power of attorney executed in another state which does not comply with the execution requirements of this part (part II of ch. 709, F.S.) is valid in Florida if the execution of the power of attorney complied with the law of the state of execution.[18] A third person who is requested to accept a power of attorney that is valid in Florida solely because of the requirement of s. 709.2106(3), F.S.,[19] may in good faith request, and rely upon, without further investigation, an

[17] See s. 695.03, F.S.
[18] This concept of portability makes powers of attorneys portable between states. See Real Property, Probate and Trust Law Section of the Florida Bar, White Paper: Chapter 709, F.S. (2011) (on file with the Senate Committee on Judiciary).
[19] The execution of the power of attorney complied with the law of the state of execution.

opinion of counsel as to any matter of law concerning the power of attorney, including the due execution and validity of the power of attorney. An opinion of counsel requested under s. 709.2106(3), F.S., must be provided at the principal's expense. A third person may accept a power of attorney that is valid in Florida solely because of s. 709.2106(3), F.S., if the agent does not provide the requested opinion of counsel, and in such case, a third person has no liability for refusing to accept the power of attorney. Subsection 709.2106(3), F.S., does not affect any other right of a third person who is requested to accept the power of attorney under this part (part II of ch. 709, F.S.), or any other provisions of applicable law.

Section 709.2106(4), F.S., provides that a military power of attorney is valid if it is executed in accordance with federal law, as amended. A deployment-contingent power of attorney may be signed in advance, and is effective upon deployment of the principal, and shall be afforded full force and effect by Florida courts.

Section 9 creates s. 709.2107, F.S., which provides that the meaning and effectiveness of a power of attorney is governed by part II of ch. 709, F.S., if it is used in Florida or the power of attorney states that it is to be governed by the laws of Florida.

Section 10 creates s. 709.2108, F.S., which specifies that except as provided in s. 709.2108(2), F.S., a power of attorney is exercisable when executed. Section 709.2108(2), F.S., provides that if a power of attorney executed before October 1, 2011, is conditioned on the principal's lack of capacity to manage property and the power of attorney has not become exercisable before that date, the power of attorney is exercisable upon delivery of an affidavit of a Florida-licensed medical or osteopathic physician. The affidavit must state that the physician is licensed to practice medicine or osteopathic medicine in Florida and that the physician believes that the principal lacks the capacity to manage property.

Except as provided in s. 709.2108(2), F.S., or s. 709.2106(4) F.S., a power of attorney is ineffective if the power of attorney provides that it is to become effective at a future date or upon the occurrence of a future event or contingency.

Section 11 creates s. 709.2109, F.S., which provides requirements for the termination or suspension of a power of attorney or an agent's authority. A power of attorney terminates when:

- The principal dies;
- The principal becomes incapacitated, if the power is not durable;
- The principal is adjudicated totally or partially incapacitated by a court, unless the court determines that certain authority granted by the power of attorney is to be exercisable by the agent;
- The principal revokes the power of attorney;
- The power of attorney provides that it terminates;
- The purpose of the power of attorney is accomplished; or
- The agent's authority terminates and the power of attorney does not provide for another agent to act under the power of attorney.

An agent's authority is exercisable until the authority terminates. An agent's authority terminates when:

- The agent dies, becomes incapacitated, resigns, or is removed by a court;
- An action is filed for the dissolution or annulment of the agent's marriage to the principal or for their legal separation, unless the power of attorney otherwise provides; or
- The power of attorney terminates.

The authority granted under a power of attorney is suspended until the petition to initiate judicial proceedings to determine the principal's incapacity, or for the appointment of a guardian advocate, is dismissed or withdrawn or the court enters an order authorizing the agent to exercise one or more powers granted under the power of attorney. The agent may petition the court in which a proceeding is pending, in the event of an emergency, for authorization to exercise a power granted under the power of attorney. The petition must set forth the nature of the emergency, the property or matter involved, and the power to be exercised by the agent.

Notwithstanding s. 709.2109, F.S., unless otherwise ordered by the court, a proceeding to determine incapacity does not affect the authority of the agent to make health care decisions for the principal, including those provided in ch. 765, F.S., which deal with health care advance directives. If a health care advance directive has been executed by the principal, the terms of the directive control if the directive and the power of attorney are in conflict, unless the power of attorney is later executed and expressly states otherwise.

Termination or suspension of an agent's authority or of a power of attorney is ineffective as to the agent who, without knowledge of the termination or suspension, acts in good faith under the power of attorney. An act so performed, unless otherwise invalid or unenforceable, binds the principal and the principal's successors in interest.

Section 12 creates s. 709.2110, F.S., which specifies requirements for the revocation of a power of attorney. A principal may revoke a power of attorney by expressing the revocation in a subsequently executed power of attorney or other writing signed by the principal. The principal may give notice of the revocation to an agent who has accepted authority under the revoked power of attorney. The execution of a power of attorney does not revoke a power of attorney previously executed by the principal except as provided in this section.

Section 13 creates s. 709.2111, F.S., which specifies requirements for co-agents and successor agents under a power of attorney. Unless the power of attorney states otherwise, each co-agent may exercise its authority independently. A principal may designate one or more successor agents to act if an agent dies, becomes incapacitated, is not qualified to serve, or declines to serve.

Except as otherwise provided in the power of attorney or s. 709.2111(4), F.S., an agent who does not participate in or conceal a breach of fiduciary duty committed by another agent, including a predecessor agent, is not liable for the actions or omissions of the other agent.

Under s. 709.2111(4), F.S., an agent who has actual knowledge of a breach or imminent breach of fiduciary duty by another agent must take reasonable actions appropriate in the circumstances

to safeguard the principal's best interests. If the principal is not incapacitated, giving notice to the principal is sufficient. An agent who fails to take action is liable to the principal for reasonably foreseeable damages that the principal could have avoided if the agent had taken such action. A successor agent does not have a duty to review the conduct or decisions of a predecessor agent. Except as provided in s. 709.2111(4), F.S., a successor agent does not have a duty to institute any proceeding against a predecessor agent or file a claim against a predecessor agent's estate, for acts or omissions of the predecessor agent as an agent of the principal. If a power of attorney requires two or more persons as co-agents to act together, one or more of the agents may delegate to a co-agent the authority to conduct banking transactions as provided in s. 709.2208(1), F.S., whether the authority to conduct banking transactions is specifically enumerated or incorporated by reference to that section in the power of attorney.

Section 14 creates s. 709.2112, F.S., which specifies requirements for the reimbursement and compensation of agents. Unless otherwise stated in the power of attorney, an agent is entitled to reimbursement of expenses reasonably incurred on behalf of the principal. Unless otherwise stated in the power of attorney, a qualified agent is entitled to compensation that is reasonable under the circumstances. Notwithstanding any provision in the power of attorney, an agent may not be paid compensation unless the agent is a qualified agent. A "qualified agent" is an agent who is the spouse of the principal, an heir of the principal, a financial institution that has trust powers and a place of business in Florida, an attorney or certified public accountant licensed in Florida, or a natural person who has never been an agent for more than three principals at the same time.

Section 15 creates s. 709.2113, F.S., which provides that, except as provided in the power of attorney, a person accepts appointment as an agent by exercising authority or performing duties as an agent or by any other assertion or conduct indicating acceptance. The scope of an agent's acceptance is limited to those aspects of the power of attorney for which the agent's assertions or conduct reasonably manifests acceptance.

Section 16 creates s. 709.2114, F.S., which specifies the duties of an agent. An agent is a fiduciary, must act only within the scope of authority granted in the power of attorney and may not act contrary to the principal's reasonable expectations actually known by the agent. The agent must act in good faith and not in a manner contrary to the principal's best interests with specified exceptions. The agent must attempt to preserve the principal's estate plan, to the extent actually known to the agent, if preserving the plan is consistent with the principal's best interests based on specified factors.[20] The agent is prohibited from delegating authority except as provided in law for the delegation of investment functions. The agent must keep records on behalf of the principal, as well as create and maintain an accurate inventory of the principal's safe-deposit box, if applicable.

[20] The mandatory duty "to preserve the principal's estate plan" is new to Florida law. Under the Uniform Powers of Attorney Act, it was a default duty rather than a mandatory one. The duty applies only to the extent the principal's estate plan is actually known by the agent and only when the preservation of the principal's estate plan is in the principal's best interest based on all relevant factors. The agent may not actually know the principal's estate plan but has a fiduciary duty to apply the relevant factors listed in the bill as to whether preservation of the estate is consistent with the principal's best interest. See discussion of the duty to preserve the principal's estate plan in White Paper, Real Property, Probate and Trust Law Section of the Florida Bar, *supra* note 4.

Except as otherwise provided in the power of attorney, the agent who has accepted appointment must act loyally for the sole benefit of the principal; act so as to not create a conflict of interest that impairs the agent's ability to act impartially in the principal's best interests; and cooperate with a person who has authority to make health care decisions for the principal to carry out the principal's reasonable expectations and otherwise act in the principal's best interests. An agent who acts in good faith is not liable to any beneficiary of the principal's estate plan for failure to preserve the plan. If an agent has special skills or expertise or was selected based on the agent's representation that the agent has such skills or expertise, then those special skills must be considered in determining whether the agent acted with care, competence, and diligence under the circumstances. Absent a breach of duty to the principal, an agent is not liable for a decline in the value of the principal's property. An agent must disclose specified information and documents within 60 days of the request or ask for additional time to comply with the request.

Section 17 creates s. 709.2115, F.S., which provides requirements for the exoneration of an agent. A power of attorney may provide for exoneration of the agent for acts or decisions made in good faith and under the power of attorney except to the extent the provision:

- Relieves the agent of liability for breach of a duty committed dishonestly, with improper motive, or with reckless indifference to the purposes of the power of attorney or the principal's best interest; or
- Was inserted as a result of an abuse of a confidential or fiduciary relationship with the principal.

Section 18 creates s. 709.2116, F.S., which provides that a court may construe or enforce a power of attorney, review the agent's conduct, terminate the agent's authority, remove the agent, and grant other appropriate relief. The following parties may petition the court: the principal or agent; a guardian, conservator, trustee, or other fiduciary acting for the principal or principal's estate; a person authorized to make health care decisions for the principal if the principal's health care is affected by the agent's actions; any other interested person; a governmental agency that has regulatory authority to protect the welfare of the principal; or a person asked to honor the power of attorney.

The court may award reasonable attorney's fees and costs in any proceeding commenced by the filing of a petition under this section. If an agent's exercise of power is challenged on the grounds that the exercise of power was affected by a conflict of interest and evidence is presented that the agent (or affiliate) had a personal interest in exercise of the power, then the agent or affiliate has the burden of proving, by clear and convincing evidence, that the agent acted solely in the interest of the principal or in good faith in the principal's best interest, and the conflict of interest was expressly authorized in the power of attorney. A provision authorizing an agent to engage in a transaction affected by a conflict of interest which is inserted into a power of attorney as the result of the abuse of a fiduciary or confidential relationship with the principal by the agent or the agent's affiliate is invalid.

The section recognizes and defines affiliates of the agent who may be involved in potential conflicts of interest in the exercise of the agent's powers. Affiliates of an agent include: the agent's spouse; the agent's descendant, siblings, parents, or their spouses; a corporation or entity

that owns a significant interest in the agent; or the agent acting in a fiduciary capacity for someone other than the principal.

Section 19 creates s. 709.2117, F.S., which outlines an agent's liability to the principal or the principal's successors in interest for violations of applicable law . The agent may be required to restore the value of the principal's property to what it would be if the violation had not occurred and to reimburse the principal or the principal's successors in interest for the attorney's fees and costs paid from the principal's funds on the agent's behalf in defense of the agent's actions.

Section 20 creates s. 709.2118, F.S., which provides requirements and methods for an agent's resignation.

Section 21 creates s. 709.2119, F.S., which provides that a third person, who in good faith accepts a power of attorney that appears to be executed in accordance with Florida law, may rely upon the power of attorney and enforce an authorized transaction against the principal's property as if the power of attorney, the agent's authority, and authority of the officer executing for or on behalf of a financial institution that has trust powers and acting as an agent were genuine, valid, and still in effect. A third person does not accept a power of attorney in good faith if the person has notice that the power of attorney or the purported agent's authority is void, invalid, or terminated.

A third person may require an agent to execute an affidavit stating where the principal is domiciled; that the principal is not deceased; that there has been no revocation, or partial or complete termination by adjudication of incapacity or by the occurrence of an event referenced in the power of attorney; that the power of attorney has not been suspended by the initiation of proceedings to determine incapacity or the appointment of a guardian for the principal; and the reasons for the unavailability of the predecessor agents if the affiant is a successor agent. A third person may require an officer of a financial institution acting as agent to provide an affidavit that meets the requirements of this section. The form of affidavit executed by an agent is provided. Additionally, third persons who act in reliance upon the authority granted to the agent and in accordance with the instructions of the agent are held harmless by the principal from any loss suffered or liability incurred as a result of actions taken before the receipt of written notice of revocation, written notice of partial or complete termination by adjudication of incapacity or by the occurrence of an event referenced in the power of attorney, notice of death of the principal, notice of suspension by initiation of proceedings to determine incapacity or to appoint a guardian, or other notice as provided in s. 709.2121, F.S.

Section 22 creates s. 709.2120, F.S., which requires a third person to accept or reject a power of attorney within a reasonable time and to state in writing the reason for the rejection. A financial institution has four days, excluding Saturdays, Sundays, and legal holidays, to accept or reject a power of attorney for banking or security transactions. A third person may not require an additional or different form of power of attorney for authority granted in the power of attorney presented. A third person is not required to accept a power of attorney if:

- The third person is not otherwise required to engage in a transaction with the principal in the same circumstances;

- The third person has knowledge of the termination or suspension of the agent's authority or of the power of attorney before exercising the power;
- A timely request by the third person for an affidavit, English transaction, or opinion of counsel is refused by the agent;
- The third person believes in good faith that the power is not valid or that the agent lacks authority to perform the act requested with exceptions; or
- The third person makes, or has knowledge that another person has made, a report to the local adult protective services office alleging that the principal may be subject to physical or financial abuse, neglect, exploitation, or abandonment by the agent or others acting for or with the agent;

A third person who refuses to accept a power of attorney, in violation of s. 709.2120, F.S., is subject to:

- A court order mandating acceptance of the power of attorney; and
- Liability for damages, including reasonable attorney's fees and costs incurred in an action that confirms the validity of the power of attorney or mandates acceptance of the power of attorney.

Section 23 creates **s.** 709.2121, F.S., which provides requirements for notice. Notice, including a notice of revocation, notice of partial or complete termination by adjudication of incapacity or by the occurrence of an event referenced in the power of attorney, notice of death of the principal, notice of suspension by initiation of proceedings to determine incapacity or to appoint a guardian, or other notice, is not effective until it is provided, in writing, to the agent or any third persons relying upon a power of attorney. Notice must be accomplished in a manner reasonably suitable under the circumstances and likely to result in receipt of the notice or document on the agent or affected third person. Notice to a financial institution must contain the name, address, and the last four digits of the principal's taxpayer identification number and be directed to an officer or manager of the financial institution in Florida. Notice is effective when given, except notice to a financial institution, brokerage company, or title company, which is not effective until 5 days, excluding Saturdays, Sundays, and legal holidays, after it is received.

Section 24 creates s. 709.2201, F.S., which outlines an agent's authority to exercise only specific authority granted to the agent except as provided in other applicable law. General provisions in a power of attorney which do not identify the specific authority granted, such as the authority to do all acts, are not an express grant of specific authority. Therefore, such general provisions do not grant any authority to the agent. Court approval is not required for any action of the agent in furtherance of an express grant of a specific authority. Authorization to an agent in a power of attorney may include authority to:

- Execute stock powers or similar documents on behalf of the principal and delegate to a transfer agent or similar person the authority to register any stocks, bonds, or other securities into or out of the principal's or nominee's name.
- Convey or mortgage homestead property with some requirements for joinder of the principal's spouse or the spouse's guardian if the principal is married.

If such authority is specifically granted in a durable power of attorney, the agent may make all health care decisions on behalf of the principal, including health care advance directives specified in ch. 765, F.S. An agent may not: perform duties under a contract that requires the exercise of personal services of the principal; make any affidavit as to the personal knowledge of the principal; vote in any public election on behalf of the principal; execute or revoke any will or codicil for the principal; or exercise powers and authority granted to the principal as trustee or as court-appointed fiduciary.

If the subjects over which authority is granted in a power of attorney are similar or overlap, the broadest authority controls. Authority granted in a power of attorney is exercisable with respect to property the principal has when the power of attorney is executed and to property the principal later acquires, whether or not the property is located in Florida and whether or not the authority is exercised or the power of attorney is executed in Florida. Acts by the agent under the power of attorney have the same effect and inure to the benefit of and bind the principal and his or her successors in interest as if the principal had performed the act.

Section 25 creates s. 709.2202, F.S., notwithstanding s. 709.2201, F.S., which provides that only if the principal signed or initialed next to each specific enumeration of the authority, the exercise of the authority is consistent with the agent's duties under s. 709.2114, F.S., and the exercise is not otherwise prohibited by another agreement or instrument, an agent may exercise the following authority:

- Create an inter vivos trust;
- Amend, modify, revoke, or terminate a trust created by or on behalf of the principal and only if the trust instrument explicitly authorizes such acts by the settlor's agent;
- Make a gift with specified limitations;
- Create or change a beneficiary designation;
- Waive the principal's right to be a beneficiary of a joint and survivor annuity, including survivor benefits under a retirement plan; or
- Disclaim property and powers of appointment.

Notwithstanding a grant of authority to do an act authorized under this section, unless the power of attorney otherwise provides, an agent who is not an ancestor, spouse or descendant of the principal may not exercise authority to create in the agent, or in an individual to whom the agent owes a legal obligation of support, an interest in the principal's property, whether by gift, right of survivorship, beneficiary designation, disclaimer, or otherwise.

Unless the power of attorney otherwise provides, a provision in a power of attorney granting general authority with respect to gift authorizes the agent to only:

- Make outright to, or for the benefit of, a person a gift of any of the principal's property in an amount per donee not to exceed the annual dollar limits of the federal gift tax exclusion without regard to whether the federal gift tax exclusion applies to the gift, or if the principal's spouse agrees to consent to a split gift in an amount per donee not to exceed twice the annual federal gift tax exclusion limit; and

- Consent to the splitting of a gift made by the principal's spouse in an amount per donee not to exceed the aggregate annual gift tax exclusions for both spouses.

Section 709.2202(4), F.S., specifies additional acts that do not require specific authority,[21] if the agent is authorized to conduct banking transactions. A bank or other financial institution does not have a duty to inquire as to the appropriateness of the agent's exercise of that authority and is not liable to the principal or any other person for actions taken in good faith reliance on the appropriateness of the agent's actions. The agent's fiduciary duties to the principal with respect to the exercise of the power of attorney under the acts specified in s. 709.2202(4), F.S., are not eliminated.

Section 709.2202, F.S., does not apply to a power of attorney executed before October 1, 2011.

Section 26 creates s. 709.2208(1), F.S., which provides that a power of attorney that includes a statement that the agent has "authority to conduct banking transactions as provided in s. 709.2208(1), F.S.," grants general authority to the agent to engage in specified transactions with financial institutions without additional specific enumeration in the power of attorney which include but are not limited to authority to:

- Establish, continue, modify, or terminate an account or other banking arrangement with a financial institution;
- Contract for services available from a financial institution;
- Withdraw, by check, order, electronic funds transfer, or otherwise, money or property of the principal deposited with or left in the custody of a financial institution;
- Receive statements of accounts, vouchers, notices, and similar documents from a financial institution and act with respect to them;
- Purchase cashier's checks, official checks, counter checks, bank drafts, money orders, and similar instruments;
- Endorse and negotiate checks, cashier's checks, official checks, drafts, and other negotiable paper of the principal or payable to the principal or the principal's order, transfer money, and accept a draft drawn by a person upon the principal and pay it when due;
- Apply for, receive, and use debit cards, electronic transaction authorizations, and traveler's checks from a financial institution;
- Use, charge, or draw upon any line of credit, credit card, or other credit established by the principal with a financial institution; and
- Consent to an extension of time of payment with respect to commercial paper or a financial transaction with a financial institution.

Section 709.2208(2), F.S., provides that a power of attorney that includes a statement that the agent has "authority to conduct investment transactions as provided in s. 709.2208(2), F.S.," grants general authority to the agent with respect to securities held by financial institutions to take specified actions without additional specific enumeration in the power of attorney which include, but are not limited to, authority to:

[21] These acts do not require specific authority: making a deposit to or withdrawal from an insurance policy, retirement account, individual retirement account, benefit plan, bank account, or any other account held jointly or otherwise held in survivorship or payable on death.

- Buy, sell, and exchange investment instruments;
- Establish, continue, modify, or terminate an account with respect to investment instruments;
- Pledge investment instruments as security to borrow, pay, renew, or extend the time of payment of a debt of the principal;
- Receive certificates and other evidences of ownership with respect to investment instruments;
- Exercise voting rights with respect to investment instruments in person or by proxy, enter into voting trusts, and consent to limitations on the right to vote; and
- Sell commodity futures contracts and call and put options on stocks and stock indexes.

"Investment instruments" is defined for purposes of s. 709.2208(2), F.S., and expressly excludes commodity futures contracts and call and put options on stocks and stock indexes.

Section 27 creates s. 709.2301, F.S., which provides that the common law of agency and principles of equity supplement this part (part II of ch. 709, F.S.), except as modified by this part (part II of ch. 709, F.S.) or other state law.

Section 28 creates s. 709.2302, F.S., which provides that this part (part II of ch. 709, F.S.) does not supersede any other law applicable to financial institutions or other entities, and that law controls if inconsistent with this part (part II of ch. 709, F.S.).

Section 29 creates s. 709.2303, F.S., which provides that the remedies under this part (part II of ch. 709, F.S.) are not exclusive and do not abrogate any right or remedy under any other law than this part (part II of ch. 709, F.S.).

Section 30 creates s. 709.2401, F.S., which provides that this part (part II of ch. 709, F.S.) modifies, limits, and supersedes the federal Electronic Signatures in Global and National Commerce Act, but does not modify, limit, or supersede s. 101(c) of that federal act or authorize electronic delivery of any of the notices described in s. 103(b) of that federal act.

Section 31. Section 709.2402 provides that, except as otherwise provided in part II (part II of ch. 709, F.S.), part II:

- Applies to a power of attorney created before, on, or after October 1, 2011, and to acts of the agent occurring on or after that date.
- An act of the agent occurring before October 1, 2011, is not affected by this part (part II, of ch. 709, F.S.).

Section 32 amends 736.0602, F.S., in order to correct a statutory cross-reference to s. 709.2202, F.S.

Section 33 repeals s. 709.01, F.S., relating to the authority of a power of attorney when the principal is dead; s. 709.015, F.S., relating to the authority of an agent under a power of attorney when the principal is listed as missing; s. 709.08, F.S., relating to a durable power of attorney; and s. 709.11, F.S., relating to a deployment-contingent power of attorney.

Section 34 provides an effective date of October 1, 2011.

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:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

CS by Judiciary on March 14, 2011:
The committee substitute corrects references to Florida licensed medical and osteopathic physicians and their duties to execute an affidavit of a principal's incapacity for a springing power of attorney to take effect at the time of the principal's incapacity. The committee substitute revises the bill to clarify that the agent of a power of attorney must attempt to preserve the principal's estate plan, as the plan is known to the agent, and as the agent applies the factors to determine whether the preservation is consistent with the

principal's best interest. The committee substitute corrects several scrivener's errors and statutory cross-references to conform to changes in the bill.

B. Amendments:

None.

632712

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment

Delete line 26
and insert:
to a physician licensed under chapter 458 or chapter 459. The physician shall

847370

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment

Delete lines 47 - 49.

495696

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment

Delete line 73
and insert:
to obtain services from a contracted provider without a

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 Banking and Insurance Committee

BILL:	SB 100
INTRODUCER:	Senator Ring
SUBJECT:	Autism
DATE:	March 25, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Fernandez/Brown	Stovall	HR	**Favorable**
2.	Johnson	Burgess	BI	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

I. Summary:

The bill requires a licensed physician, other than one providing emergency services and care, to screen a minor for autism spectrum disorder (ASD) when the parent or legal guardian of the minor believes the minor exhibits symptoms of ASD and notifies the physician. Based on a determination by the physician of medical necessity or lack thereof, the physician must refer the minor for additional ASD screening or inform the parent or legal guardian of other available ASD screening options.

The bill requires health insurers and health maintenance organizations (HMOs) to provide coverage for "direct patient access," as defined in the bill, to an appropriate specialist for screening for or evaluation or diagnosis of ASD. The bill mandates that health insurance policies and HMO contracts provide coverage for a minimum of three visits per policy year for that purpose.

The bill substantially amends the following sections of the Florida Statutes: 627.6686 and 641.31098.

The bill creates the following section of the Florida Statutes: 381.986.

II. Present Situation:

What is Autism?

Autism is a term used to describe a group of complex developmental disabilities that many researchers believe are the result of a neurological disorder that affects the functioning of the brain. Individuals with autism often have problems communicating with others through spoken language and nonverbal communication. The early signs of autism usually appear in the form of developmental delays before a child turns 3 years old.[1]

Section 393.063(3), F.S., defines autism as: ". . . a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests."

The various forms of autism are referred to as the autism spectrum disorders, meaning that autism can be manifested in a wide variety of combinations, from mild to severe. Thus, many different behaviors can indicate that a person should be diagnosed as autistic.

According to the National Institute of Mental Health (NIMH),[2] the pervasive developmental disorders, or ASDs, range from a severe form, called autistic disorder, to a milder form, Asperger's syndrome.[3] If a child has symptoms of either of these disorders, but does not meet the specific criteria for either, the diagnosis is called pervasive developmental disorder not otherwise specified (PDD-NOS). Other rare, severe disorders that are included in the autism spectrum are Rett syndrome[4] and childhood disintegrative disorder.[5]

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[1] Centers for Disease Control and Prevention website, Found at: <http://www.cdc.gov/ncbddd/autism/signs.html> (Last visited on March 17, 2011).

[2] Department of Health and Human Services, National Institute of Mental Health. *Autism Spectrum Disorders: Pervasive Developmental Disorders.* Printed 2004 Reprinted 2008. Found at: <http://www.nimh.nih.gov/health/publications/autism/nimhautismspectrum.pdf> (Last visited on March 17, 2011).

[3] The NIMH states that children with Asperger's syndrome are similar to high-functioning children with autism in that their language and intelligence remain intact. Like autistic children, persons with Asperger's syndrome have repetitive behaviors, severe social problems, and clumsy movements. The symptoms of Asperger's syndrome usually appear later in childhood than those of autism.

[4] The NIMH provides the following explanation of Rett syndrome: Rett syndrome is relatively rare, affecting almost exclusively females, one out of 10,000 to 15,000. After a period of normal development, sometime between 6 and 18 months, autism-like symptoms begin to appear. The little girl's mental and social development regresses—she no longer responds to her parents and pulls away from any social contact. If she has been talking, she stops; she cannot control her feet; she wrings her hands. Some of the problems associated with Rett syndrome can be treated. Physical, occupational, and speech therapy can help with problems of coordination, movement, and speech.

[5] The NIMH provides the following explanation of childhood disintegrative disorder: Very few children who have an ASD diagnosis meet the criteria for childhood disintegrative disorder (CDD). An estimate based on four surveys of ASD found fewer than two children per 100,000 with an ASD could be classified as having CDD. This suggests that CDD is a very rare form of ASD. It has a strong male preponderance. Symptoms may appear by age 2, but the average age of onset is between 3 and 4 years. Until this time, the child has age-appropriate skills in communication and social relationships. The long period of normal development before regression helps differentiate CDD from Rett syndrome. The loss of such skills as vocabulary is more dramatic in CDD than they are in classical autism. The diagnosis requires extensive and pronounced losses involving motor, language, and social skills. CDD is also accompanied by loss of bowel and bladder control and oftentimes seizures and a very low IQ.

The NIMH states that all children with an ASD demonstrate deficits in:

- *Social Interaction* – Most children with an ASD have difficulty learning to engage in everyday human interaction. Children with an ASD are also slower in understanding subtle social cues (nonverbal communication) and thus struggle to interpret what others are thinking and feeling. This may cause them to find social interaction confusing and frustrating. It is also common for people with an ASD to have difficulty controlling their emotions. Examples include episodes of disruptive behavior such as crying or verbal outbursts at inappropriate times or physical aggression. Autistics often can lose self control when exposed to a strange, overwhelming environment or when they become angry or frustrated.
- *Verbal and nonverbal communication* – Autistics have difficulty developing standard communication skills. Some children with an ASD remain mute, while others do not develop language until ages 5 to 9. Others use language in unusual ways or utilize sign language or pictures to communicate. The body language of autistics can be difficult to understand because it is not always consistent with the words they are saying. As they grow older, persons with an ASD often become more aware of their difficulties in communication, which can lead to anxiety or depression.
- *Repetitive behaviors or interests* – Children with an ASD often perform odd repetitive motions that set them apart from their peers. For example, some children and adults repeatedly flap their arms or walk on their toes while others freeze in position. Children with an ASD exhibit the need for consistency in their environment. Changes in daily routines—such as mealtimes, dressing, bathing, going to school at a certain time and by the same route—can cause autistics to become extremely disturbed. As children, they might spend hours lining up their toys in a certain way and if the toys are moved, they become upset. Additionally, autistics often form intense, obsessive preoccupations with certain objects or topics on which they focus much of their energy.

Another common difficulty is that children with an ASD often have unusual responses to sensory experiences, such as certain sounds or the way objects look.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is the primary system used to classify and diagnose mental disorders. The 4th edition of the DSM was released in 1994. On February 10, 2010, the American Psychiatric Association released its draft criteria for the fifth edition of the DSM on its website.[6] The draft DSM-5 includes collapsing all autism related diagnoses into one single category, "autism spectrum disorder" that would incorporate autistic disorder, Asperger's syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. The final DSM-5 is not scheduled for release until May 2013.

Sections 627.6686(2)(b) and 641.31098(2)(b), F.S., define the term "autism spectrum disorder" as any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

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[6] Proposed Draft Revisions to DSM Disorders and Criteria. Found at: <http://www.dsm5.org/Pages/Default.aspx> (Last visited on March 17, 2011).

- Autistic disorder.
- Asperger's syndrome.
- Pervasive developmental disorder not otherwise specified.

The law requires certain insurance coverage for diagnostic screening, intervention, and treatment of autism spectrum disorder for eligible individuals and defines an eligible individual as:

> . . .an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.[7]

Diagnosis of Autism Spectrum Disorders

There is no medical test for ASDs. Instead, doctors look at behavioral symptoms to make a diagnosis. These symptoms may show up within the first few months of life or may appear at any time before the age of 3.[8]

According to the Centers for Disease Control and Prevention (CDC), research shows that the diagnosis of autism at age 2 can be reliable, valid, and stable. However, many children do not receive final diagnosis until they are much older. This delay in diagnosis may result in lost opportunities for specialized early intervention.[9]

The diagnosis of an ASD is a two-stage process. The first stage involves developmental screening during "well child" check-ups. These screening tests are used solely for identifying children with developmental disabilities. Additional screening may be needed if a child is at high risk[10] for an ASD or if the symptoms warrant it.[11]

The second stage of diagnosis is a comprehensive evaluation. If the initial screening tests indicate the possibility of an ASD, then further comprehensive testing is performed. Comprehensive testing is done by health care practitioners from multiple disciplines (psychologists, psychiatrists, neurologists, speech therapists, and other professions with experience in diagnosing children with an ASD) that evaluate the child in depth and determine if there is a developmental disorder, and if so, render a diagnosis. This may include:[12]

- Clinical observations;
- Parent interviews;

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[7] ss. 627.6686(2)(c) and 641.31098(2)(c), F.S.
[8] Centers for Disease Control and Prevention website. Found at: <http://www.cdc.gov/ncbddd/autism/screening.html> (Last visited on March 17, 2011).
[9] Centers for Disease Control and Prevention website. Found at <http://www.cdc.gov/ncbddd/autism/screening.html> (Last visited on March 17, 2011).
[10] The CDC considers a child with a sibling or parent with an ASD to be at high risk.
[11] Centers for Disease Control and Prevention website, Found at <http://www.cdc.gov/ncbddd/autism/screening.html> (Last visited on March 17, 2011).
[12] Centers for Disease Control and Prevention website, Found at <http://www.cdc.gov/ncbddd/autism/screening.html> (Last visited on March 17, 2011).

- Developmental histories;
- Psychological testing;
- Speech and language assessments;
- The possibility of the use of one or more autism diagnostic scales; and
- The possibility of physical, neurological, and genetic testing.

Treatment Approaches

Much of the scientific and clinical evidence indicates that early treatment of autism during preschool years (ages 3 to 5) often yields positive results in mitigating the effects of ASDs. According to the National Institute of Neurological Disorders and Stroke (NINDS), therapies for autism are designed to remedy specific symptoms.[13] Educational and behavioral interventions are highly-structured and usually aimed at the development of skills such as language and social skills. Medication may be prescribed to reduce self-injurious behavior or other behavioral symptoms of autism. Early intervention is important for children because children learn most rapidly when they are very young. If begun early enough, such intervention has a chance of favorably influencing brain development. In a 2001 report, the Commission on Behavioral and Social Sciences and Education recommended that treatment "services begin as soon as a child is suspected of having an autistic spectrum disorder. Those services should include a minimum of 25 hours a week, 12 months a year, in which the child is engaged in systematically planned, and developmentally appropriate educational activity toward identified objectives."[14]

The Center for Autism and Related Disabilities provided the following information concerning the application of speech-language therapy, occupational therapy, and physical therapy for individuals with autism:

- *Speech-Language Therapy:* People with autism usually have delays in communication. Speech therapists look for a system of communication that will work for an individual with autism and may consider alternatives to the spoken word such as signing, typing, or a picture board with words.
- *Occupational Therapy:* Commonly, this therapy focuses on improving fine motor skills, such as brushing teeth, feeding, and writing, or sensory motor skills that include balance, awareness of body position, and touch.
- *Physical Therapy:* This therapy specializes in developing strength, coordination, and movement.

According to the NIMH, a number of treatment approaches have evolved in the decades since autism was first identified. These approaches include developmental, behaviorist, and nonstandard. Developmental approaches provide consistency and structure along with appropriate levels of stimulation.

[13] National Institutes of Health, National Institute of Neurological Disorders and Stroke, Autism Information Page. Found at: <http://www.ninds.nih.gov/disorders/autism/autism.htm#Is_there_any_treatment> (Last visited on March 18, 2011).
[14] Commission on Behavioral and Social Sciences and Education, *Educating Children with Autism* 6, 2001. Found at: <http://www.nap.edu/openbook.php?record_id=10017&page=66> (Last visited on March 18, 2011).

Behaviorist training approaches are based on rewarding individuals for a certain type of behavior. Dr. Ivar Lovaas pioneered the use of behaviorist methods for children with autism more than 25 years ago. Lovaas therapy involves time-intensive, highly structured, repetitive sequences in which a child is given a command and rewarded each time he responds correctly. Using this approach for up to 40 hours a week, some children may be brought to the point of near-normal behavior. Others are much less responsive to the treatment. However, some researchers and therapists believe that less intensive treatments, particularly those begun early in a child's life, may provide the same level of efficacy.

Health Insurance Coverage for Autism Spectrum Disorders in Florida

In 2008, the Legislature passed CS/CS/SB 2654, which included the *Steven A. Geller Autism Coverage Act* and the *Window of Opportunity Act*.[15]

The Window of Opportunity Act required the Office of Insurance Regulation (OIR) to convene a workgroup of stakeholders by August 31, 2008, to negotiate a compact for a binding agreement among the participants relating to insurance coverage and access to services for persons with developmental disabilities. The law required the compact to include coverage for behavioral analysis and behavior assistant services, speech therapy, physical therapy, and occupational therapy when medically necessary; policies and procedures for notifying policy holders of the amount, scope, and developmental disability conditions covered. In addition, the compact was to provide penalties for documented cases of denial of claims for medically necessary services due to the presence of a developmental disability. The law also required the compact to provide proposals for new product lines that may be offered in conjunction with traditional health insurance to provide a more appropriate means of spreading risk, financing costs, and accessing favorable prices.

In September 2008, the OIR convened the Developmental Disabilities Compact Workgroup to develop the compact required in law. A compact was developed by the workgroup and adopted on December 17, 2008.[16] Insurers and HMOs that sign onto the compact agreement must provide coverage for developmental disabilities as specified in the compact for all plans issued or renewed after January 1, 2010. The OIR reports that Total Health Choice is the only health insurer that has signed onto the autism compact.[17]

All insurers and HMOs that did not sign the Developmental Disabilities Compact Workgroup by April 1, 2009, are subject to the requirements of the Steven A. Gellar Autism Act. The Act requires insurers, including the state group insurance plan, to provide coverage for well-baby and child screening for diagnosing the presence of autism and to cover the treatment of autism through applied behavioral analysis and assistant services, physical therapy, speech therapy, and occupational therapy.[18] The autism disorders covered in the law are: autistic disorder, Asperger's

[15] *See* ch. 2008-30, L.O.F.
[16] Developmental Disabilities Compact. Found at: <http://www.floir.com/pdf/DDCProposal-A.pdf> (Last visited on March 18, 2011).
[17] Florida Department of Financial Services Library. Found at: http://www.myfloridacfo.com/consumers/insurancelibrary/index.htm#insurance/l_and_h/health_coverages/health_coverage_-_autism_and_developmental_disabilities.htm (last visited on March 18, 2011).
[18] ss. 627.6686 and 641.31098, F.S.

syndrome, and pervasive developmental disorder not otherwise specified. The insurance coverage is limited to $36,000 annually with a $200,000 total lifetime benefit. Beginning January 1, 2011, the coverage maximum will increase with inflation.

State Group Health Insurance Program

The Division of State Group Health Insurance of the Department of Management Services offers health insurance benefits for state and political subdivision employees.[19] On January 1, 2010, the State Group Health Insurance Program implemented the requirements of the Steven A. Geller Autism Coverage Act, which requires comprehensive coverage for the screening, diagnosis, and treatment of autism spectrum disorder. The State Group Insurance Plan is required to cover well-baby and child screening for diagnosing the presence of autism and to cover the treatment of autism through applied behavior analysis and assistant services, physical therapy, speech therapy and occupational therapy. The disorders covered are autistic disorder, Asperger's syndrome and pervasive developmental disorder not otherwise specified. Children under age 18 or in high school are covered.

III. Effect of Proposed Changes:

Section 1 creates s. 381.986, F.S., to require a licensed physician to screen a minor for ASD, in accordance with the American Academy of Pediatrics' guidelines,[20] when the parent or legal guardian of the minor believes the minor exhibits symptoms of ASD and notifies the physician. If the physician determines that a referral to a specialist is medically necessary, he or she must refer the minor to an appropriate specialist to determine whether the minor meets diagnostic criteria for ASD. If the physician determines that a referral to a specialist is not medically necessary, the physician must inform the parent or guardian that he or she can self-refer to the Early Steps Program[21] or other specialist in autism. The bill exempts physicians providing emergency services and care[22] from this requirement.

An "appropriate specialist" is defined in the bill as a qualified professional who is experienced in the evaluation of autism spectrum disorder, is licensed in this state, and has training in validated diagnostic tools. The term includes, but is not limited to:

- A psychologist;
- A psychiatrist;
- A neurologist;
- A developmental or behavioral pediatrician; or
- A professional whose licensure is deemed appropriate by the Children's Medical Services Early Steps Program within the Department of Health.

[19] *See* s. 110.123(3)(b), F.S.
[20] Greenspan et. al., "Guidelines for Early Identification, Screening, and Clinical Management of Children With Autism Spectrum Disorders," *Pediatrics: Official Journal of the American Academy of Pediatrics,* April 2008, vol. 121, no. 4, p. 828.
[21] Early Steps is Florida's early intervention system that offers services to eligible infants and toddlers (birth to thirty-six months) with significant delays or a condition likely to result in a developmental delay. Early intervention is provided to support families and caregivers in developing the competence and confidence to help their child learn and develop. *See* http://www.doh.state.fl.us/alternatesites/cms-kids/families/early_steps/early_steps.html
[22] *See* s. 395.1041, F.S.

Sections 2 and 3 amends ss. 627.6686 and 641.31098, F.S., to mandate that health insurance plans and health maintenance contracts provide coverage for direct patient access to an appropriate specialist, as defined by the bill in s. 381.986, F.S, (see above) for a minimum of three visits per policy year for screening for or evaluation or diagnosis of ASD.

The bill defines "direct patient access" as the ability of an insured to obtain services from an in-network provider without a referral or other authorization before receiving services.

Section 4 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may increase the total number and cost of claims incurred by insurers and HMOs for evaluations because more minors may be referred for ASD screening or visit specialists under the direct patient access provision. If so, the bill may cause health insurance costs to increase by an indeterminate amount.

C. Government Sector Impact:

Division of State Group Insurance/Department of Management Services
The Division of State Group Insurance within the Department of Management Services (DMS) examined the bill for fiscal impact on the State Group Health Insurance Program. DMS advises that because the bill requires coverage for direct patient access and a minimum of three visits per policy year for autism spectrum screenings (in addition to the non-specialist opinion of the primary care physician), the bill could result in marginally higher cost if medically unnecessary repetition of valid screenings occurs.

The DMS solicited comments from the five HMOs that are part of the program and two of the five indicated that the bill would have a fiscal impact. HMO 1 noted the impact as indeterminate and HMO 2 estimates the fiscal impact as $4.00 per member per month. The estimated fiscal impact for the two HMOs is provided below.

HMO	FY 2011-12	FY 2012-13	FY 2013-14
HMO 1	Indeterminate	Indeterminate	Indeterminate
HMO 2	$741,936	$769,584	$795,744

Department of Health

The Department of Health has provided the following fiscal analysis:

- The bill could result in additional families seeking ASD screening from the Early Steps Program, which would increase the program's screening costs.
- The bill could increase the number children in the program who need early intervention services, which could result in further increased costs and in the inability of the Early Steps Program to ensure that appropriate early intervention services are available to eligible children.
- The exact fiscal impact is indeterminate.

VI. Technical Deficiencies:

Section 1 refers to "a physician licensed in this state." It may be more appropriate to specify a physician licensed under ch. 458 or ch. 459, F.S.

Section 1 defines the term "appropriate specialist," in part, with the phrase "has training in validated diagnostic tools." However, the term "validated diagnostic tools" is defined neither in the bill nor in existing Florida law, leaving ambiguous the standard(s) by which a diagnostic tool may be considered "validated."

Section 2, which amends s. 627.6686, F.S., defines "direct patient access" using the term "in-network" provider. However, not all health plans governed by this statute have "networks" or "in-network" providers, instead, they might have "contracted" providers.

VII. Related Issues:

Section 624.215, F.S., requires every person or organization seeking consideration of a legislative proposal mandating health coverage to submit to the Agency for Health Care Administration and the appropriate legislative committees having jurisdiction a report assessing the social and financial impacts of the proposed coverage. The Senate Committee on Health Regulation has not received a report analyzing the mandated coverage for direct patient access to an appropriate specialist for a minimum of three visits per policy year as created by the bill.

VIII. Additional Information:

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

B. Amendments:

None.

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 203 - 1533

and insert:

Section 3. Present subsections (10), (11), and (12) of section 817.234, Florida Statutes, are renumbered as subsections (11), (12), and (13), respectively, and a new subsection (10) is added to that section, to read:

817.234 False and fraudulent insurance claims.—

(10) In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle

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insurance contract is subject to a civil penalty.

(a) Except for a violation of subsection (9), the civil penalty shall be:

1. A fine up to $5,000 for a first offense.

2. A fine greater than $5,000, but not to exceed $10,000, for a second offense.

3. A fine greater than $10,000, but not to exceed $15,000, for a third or subsequent offense.

(b) The civil penalty for a violation of subsection (9) must be at least $15,000, but may not exceed $50,000.

(c) The civil penalty shall be paid to the Insurance Regulatory Trust Fund within the Department of Financial Services and used by the department for the investigation and prosecution of insurance fraud.

(d) This subsection does not prohibit a state attorney from entering into a written agreement in which the person charged with the violation does not admit to or deny the charges but consents to payment of the civil penalty.

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

And the title is amended as follows:

Delete lines 12 - 112

and insert:

statement regarding insurance fraud; amending s. 817.234, F.S.; providing civil penalties for fraudulent insurance claims involving motor vehicle insurance; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1930
INTRODUCER:	Senator Bogdanoff
SUBJECT:	Motor Vehicle Personal Injury Protection Insurance
DATE:	March 27, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Pre-meeting**
2.			CJ	
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 1930 revises the Florida Motor Vehicle No-Fault Law (No-Fault Law) and related statutory provisions. The bill:

- Requires law enforcement officers to use the *Florida Traffic Crash Report—Long Form* in accidents involving passengers or passenger complains of pain or discomfort.
- Requires an "Insurance Fraud Notice" to be included within the application for health care clinic licensure.
- Establishes the Fight Auto Fraud Fund direct support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud.
- Requires requests for the disclosure of liability insurance information made to a self-insured corporation to be sent by certified mail to the entity's registered agent.
- Creates additional language expressing the Legislative intent of the Florida Motor Vehicle No-Fault Law.
- Defines "Claimant" to mean the person, organization, or entity seeking benefits, including all assignees.
- Revises provisions regarding Personal Injury Protection (PIP) policies offering a Preferred Provider (PPO) option for medical benefits. The bill authorizes motor vehicle insurers to contract with a health insurer to use its existing PPO network. The bill authorizes insurers to offer a discount to policyholders that select a policy that uses a PPO network to provide PIP benefits and specify that reimbursement will only be provided to network providers.
- Requires a clinic or entity that initially submits a PIP claim to an insurer to include a sworn affidavit that documents it is eligible to receive reimbursement.

- Requires the insured and a medical provider that accepts an assignment of no-fault benefits to comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO).
- Revises provisions related to demand letters.
    - The claimant filing suit must submit the demand letter.
    - A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
    - Demand letters may not be used to request record production from the insurer.
    - If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Specifies that the insurer does not have notice of the amount of covered loss or medical bills unless the statements and bills are properly completed in their entirety.
- Requires health care providers to provide disclosures and patient logs to the injured person describing treatment in readable language. The provider must provide copies of the patient log within 30 days after receiving a written request from the insurer.
- Clarifies the Medicare fee schedule in effect of January 1 will be the PIP fee schedule for the entire calendar year.
- States that the insurer may define in the insurance policy what constitutes "reasonable proof" that the insurer is not liable to provide PIP benefits.
- Tolls the 30-day period for payment if the insurer reasonably believes a fraudulent insurance act was committed. The insurer must investigate and reach a claims decision within 120 days.
- Prohibits a claimant from recovering PIP benefits if the claimant submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. The claimant is not entitled to any PIP benefits regardless of whether a portion of the claim is legitimate.
- Prohibits a provider from billing the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts.
- Authorizes the insurer to require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer.
- Creates a rebuttable presumption that the injured party's failure to appear for a mental or physical examination was unreasonable. The insurer is not liable for PIP benefits incurred after the day the insurer first requested an examination if the injured person unreasonably refuses to submit to an examination.
- Authorizes an insurer to conduct an on-site physical review and examination of the treatment location.
- Specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider.
- Prohibits a claimant from filing suit until it complies with the insurer's investigation.
- Provides that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement.

The bill is effective upon becoming a law.

This bill substantially amends the following sections of the Florida Statutes: 316.066, 400.991, 627.4137, 627.730, 627.731, 627.732, 627.736, 324, 324.021, 456.057, 627.7401, and 817.234.

This bill creates the following section of the Florida Statutes: 626.9894

II. Present Situation:

Florida Motor Vehicle No-Fault Law
Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase $10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and non-economic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person and $20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income, 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a $10,000 minimum benefit. A $5,000 death benefit is also provided.

In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.[1] The re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to $10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation
- or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals;
- Licensed health care clinics that are accredited by a specified accrediting organization.

Medical Fee Limits for PIP Reimbursement

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

[1] (Chapter 2007-324, L.O.F.)

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B;
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Recently, Florida has experienced an increase in motor vehicle related insurance fraud. The number of staged motor vehicle accidents received by the Division of Insurance Fraud (Division)[2] has nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). The Division is also reporting sizeable increases in the overall number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. Florida led the nation in staged motor vehicle accident "questionable claims"[3] from 2007-2009, according to the National Insurance Crime Bureau (NICB).[4]

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled Florida's Motor Vehicle No-Fault Law, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud referrals received by the Division of Insurance Fraud during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 hundred PIP fraud referrals received by the division during the 2009/2010 fiscal year. Given this fact, the following

[2] The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.
[3] The NICB defines a "questionable claim" as one in which indications of the behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.
[4] The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies with law enforcement

description from the 2005 report is an accurate description of the current situation regarding motor vehicle insurance fraud:

> "Florida's no-fault laws are being exploited by sophisticated criminal organizations in schemes that involve health care clinic fraud, staging (faking) car crashes, manufacturing false crash reports, adding occupants to existing crash reports, filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies for medically unnecessary or non-existent treatments, and patient-brokering…

Fraudulent claims are a major cost-driver and result in higher motor vehicle insurance premium costs for Florida policyholders. Representatives from the Division of Insurance Fraud have identified the following as sources of motor vehicle insurance fraud:

- Ease of health care clinic ownership.
- Failure of some law enforcement crash reports to identify all passengers involved in an accident.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services.
- Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

Examinations Under Oath

The standard motor vehicle insurance policy contains a provision requiring the insured or claimant to submit to an examination under oath (EUO) as often as the insurer may reasonably require. When an insurer seeks an EUO of an insured or claimant, it sends a written request setting forth the time, date, and location of the examination and a list of any documents that the insurer is requesting. The examination is similar to a legal deposition as the insured answers questions posed by insurance company's attorney.

Medical providers and insurers dispute whether an insurer may require a medical provider who has accepted an assignment of benefits to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co.*,[5] that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. The court stated that under Florida law, the assignment of contract rights (here, to receive reimbursement for PIP medical benefits) does not entail the transfer of contract duties (to submit to an EUO) unless the assignee agrees to accept the duty. The court noted that the assignment does not extinguish the duty to comply with the insurance contract, but stated that it is the contracting party (the insured) who must comply with contract conditions. The majority decision also found that State Farm attempted to impermissibly alter via contract the state's No-Fault Law, which provides how insurers may obtain information from health care providers and that. A dissent in the case stated that the policy required the medical provider to submit to an examination under oath because the State Farm policy clearly stated that the medical provider must submit to an EUO under the State

[5] *Shaw v. State Farm Fire and Casualty Company*, 37 So.3d 329 (Fla. 5th DCA 2010).

Farm policy because it required each "claimant" to submit to an EUO. The dissent also stated that an assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.

Demand Letter

Prior to filing a legal action to recover PIP benefits, the insured or provider must send written notice to the insurer of an intent to initiate litigation. The notice must include an itemized statement detailing the exact amount and type of treatment asserted to be due. If the insurer pays the claim within 30 days (with interest and penalty) after receiving the demand letter then no action may be brought against the insurer. A suit may not be filed to obtain benefits and potentially collect attorney's fees until the end of this 30-day period.

Florida Uniform Crash Reports

Section 316.066, F.S., provides that a Florida Traffic Crash Report-Long Form must be completed and submitted to the Department within 10 days after an investigation by every law enforcement who, in the regular course of duty, investigates a motor vehicle crash that resulted in death or personal injury, that involved a violation of s. 316.061(1), F.S., or s. 316.193, F.S., and in which a vehicle was rendered inoperative to a degree that required a wrecker to remove it from traffic, if the action is appropriate, in the officer's discretion. For every crash for which a Florida traffic crash report long form is not required by s. 316.066, F.S., the law enforcement officer may complete a short form crash report or provide a short form crash report to be completed by each party involved in the crash.

Health Care Clinic Licensure

The Health Care Clinic Licensure Act (ss. 400.990-400.995, F.S.) was enacted by the 2003 Legislature for the purpose of preventing cost and harm to consumers by providing for the licensure, establishment and enforcement of basic standards for health care clinics. The definition of a health care "clinic" is expansive: "an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider."[6] However, the statute contains a multitude of exemptions from licensure. For instance, an entity owned by a Florida-licensed health care practitioner or by a Florida-licensed health care facility is exempt from the clinic licensure requirements. Furthermore, clinic exemptions are voluntary and the Agency for Health Care Administration (AHCA) has no statutory authority to verify that an entity qualifies for an exemption as claimed. As of January 20, 2011, there were 3,417 licensed health care clinics and 7,956 exemptions from licensure.

An applicant[7] for clinic licensure must submit to and pass a level 2 background screening pursuant to section 435.04, Florida Statutes, which requires taking fingerprints of each applicant and conducting a statewide criminal history check through the Department of Law Enforcement (FDLE) and national criminal history check through the Federal Bureau of Investigation (FBI).

[6] Section 400.9905(4), F.S.
[7] An applicant is any person with a 5 percent or more ownership interest in the clinic. See s. 400.9905(2), F.S.

AHCA also reviews the finances of the proposed clinic and inspects the facility to verify that the proposed clinic complies with licensure requirements.

Direct Support Organizations

A direct service organization (DSO) collects funds through grants, donations and other sources, and distributes them to entities that will use the funds to further a legislative purpose. Florida's nondelegation doctrine derives from Article II, Section 3 of the Florida Constitution and prohibits one branch of government from encroaching on another branch's power and also prohibits any branch from delegating its constitutionally assigned powers to another branch.[8] Accordingly, a DSO cannot exceed its grant of statutory authority. Additionally, as a statutorily created organization, the DSO is subject to the Government in the Sunshine law under ch. 119, F.S.[9] Furthermore, DSOs are required to submit an audit, conducted by an independent certified public accountant, to the Auditor General within five months after the end of the fiscal year.[10]

III. Effect of Proposed Changes:

Section 1. Amends s. 316.066(1), F.S., to require the law enforcement officer investigating a motor vehicle crash to use the *Florida Traffic Crash Report—Long Form* if passengers are in any of the vehicles involved in the crash or any party or passenger complains of pain or discomfort. The long-form and short-form crash report must also list the names and addresses of all passengers involved in the crash and identify the vehicle where the passenger was located. The bill also specifies that the investigating officer may testify at trial or provide a signed affidavit to confirm or supplement the information on the long-form or short-form report.

Section 2. Amends s. 400.991(6), F.S., to require an "Insurance Fraud Notice" to be included within the application for health care clinic licensure and the application for an exemption from such licensure. The notice states that submitting a false, misleading, or fraudulent application or document when applying for health care clinic licensure, seeking an exemption from licensure, or demonstrating compliance with Part X of ch. 400, F.S. (the Health Care Clinic Act) is a fraudulent insurance act pursuant to s. 626.989, F.S. Such act is subject to investigation by the Division of Insurance Fraud and grounds for discipline by the appropriate licensing board of the Florida Department of Health.

Section 3. Creates s. 626.9894, F.S., establishing the Fight Auto Fraud Fund (Fund) direct support organization to support the prosecution, investigation, and prevention of motor vehicle insurance fraud. The Fund will operate under a written contract with the Division of Insurance Fraud that requires the division to approve the Fund's articles of incorporation and bylaws, approve the annual budget, and certify that the Fund is complying with the terms of the contract

[8] See *Fla. Dep't of State, Div. of Elections v. Martin*, 916 So.2d 763, 769 (Fla.2005)
[9] *See* s. 119.011(2), F.S. (defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, *or other separate unit of government created or established by law including, for the purposes of this chapter*, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, *and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency*.") (emphasis added). See also *Crespo v. Florida Entertainment Direct Support Organization, Inc*., 674 So.2d 154 (Fla. 3rd DCA 1996).
[10] *See* ss. 11.45, 215.981, F.S.

and consistent with the goals of the DFS and best interests of the state. The Fund's contract with the Division of Insurance Fraud must provide for the allocation of monies to address motor vehicle fraud and the reversion of money and property held in trust by the Fund if it ceases to exist.

The Fund must be a not-for-profit corporation under ch. 617, F.S., and use all of its grants and expenditures solely to prevent and decrease motor vehicle insurance fraud. The fund is authorized to obtain money and property necessary to conduct its mission to allocate monies to address motor vehicle fraud in the following ways:

- Raise funds;
- Request and receive grants, gifts, and bequests of money; and
- Acquire, receive, hold, invest, and administer securities, funds, and real or personal property.

The Fund may make grants and expenditures that directly or indirectly benefit the Division of Insurance Fraud, state attorneys' offices, the statewide prosecutor, the Agency for Health Care Administration (AHCA), and the Department of Health. Grants or expenditures made by the Fund must be used exclusively to prevent, investigate, and prosecute motor vehicle insurance fraud. Proper grants and expenditure include the salaries or benefits of dedicated motor vehicle insurance fraud investigators, prosecutors, or support personnel so long as the money does not interfere with prosecutorial independence or create conflicts of interest that threaten the prosecution's success.

Moneys received by the Fund may be held in a separate depository account in the Fund's name but are subject to the written contract with the Division of Insurance Fraud. The DFS is authorized to permit the Fund to use department property without expense and is granted rulemaking authority to prescribe the procedures and conditions for use of department property. Use of grants or expenditures to lobby is prohibited and the Fund is subject to an annual financial audit. All contributions made by an insurer are allowed as an appropriate business expense for regulatory purposes.

The Fund will have a 7-member board of directors consisting of the Chief Financial Officer (or designee), two state attorney's appointed by the Attorney General, two representatives of motor vehicle insurers appointed by the Chief Financial Officer, and two representatives of local law enforcement agencies (the CFO and Attorney General each get one appointment). Board-members serve a 4 year term, until the appointing officer leaves office, or until the member ceases to be qualified. The Fund's contract must provide criteria for use by the Fund's board of directors to evaluate the effectiveness of the Fund's spending to combat fraud.

Section 4. Amends s. 627.4137, F.S., which requires an insurer to provide a sworn disclosure setting forth information regarding each known policy providing liability insurance that may be available to pay a claim. The sworn statement must include the names of the insurer and each insured, the liability coverage limits, a copy of the policy, and a statement of all defenses the insurer reasonably believes it has. The bill requires requests for the disclosure made to a self-insured corporation must be sent by certified mail to the registered agent of the disclosing entity.

Section 5. Amends s. 627.730, F.S., to clarify that s. 627.7407, F.S., is part of the Florida Motor Vehicle No-Fault Law.

Section 6. Amends s. 627.731, F.S., to create additional intent language for the Florida Motor Vehicle No-Fault Law. Current law states that the purpose of the no-fault law is to require motor vehicle insurance that provides specified benefits without regard to fault, to require the registration of motor vehicles, and create a limitation on the right to claim damages for pain, suffering, mental anguish, and inconvenience. The bill expands upon this language by stating that the Legislature intends to balance the insured's interest in prompt claim payment with the public's interest in reducing fraud, abuse, and overuse of the no-fault system. Accordingly, the investigation and prevention of fraudulent insurance acts must be enhanced, additional sanctions for such acts must be imposed. The intent language also specifies how the Legislature intends the no-fault law to be interpreted. The no-fault law should be construed according to the plain language of the statutory provisions, which are designed to meet the goals specified by the legislature.

The Legislature provides two findings of fact within the intent language. The first is that automobile insurance fraud remains a major problem for state consumers, as evidenced by the National Insurance Crime Bureau's finding that the state is amongst those with the highest number of fraudulent and questionable clams. The second finding of fact is that the current regulatory process for health care clinics is not adequately preventing fraudulent insurance acts with respect to licensure exemptions and compliance.

The intent language concludes with statements of legislative intent regarding various provisions of the bill:

- The provisions, schedules and procedures authorized under the no fault law are effective regardless of their express inclusion in an insurance policy, and an insurer need not amend its policy to implement them.
- In order to properly investigate a claim, the insurer must be able to take pre-litigation examinations under oath and sworn statements of claimants and request mental and physical examinations of persons seeking PIP coverage or benefits.
- Any false, misleading, or fraudulent activity renders the entire claim invalid. Insurers must be able to raise fraud as a defense to a PIP claim when there has not been an adjudication of guilt or a determination of fraud by the DFS.
- Insurers should toll the payment or denial of a claim if the insurer reasonably believes that a fraudulent insurance act has been committed.
- A rebuttable presumption must be established that a person was not involved in a motor vehicle accident if that person's name is not in the police report.
- Courts should limit attorney fee awards to eliminate the incentive for attorneys to manufacture unnecessary litigation because the insured's interest in obtaining competent counsel should be balanced with the public's interest in a no-fault system that does not encourage unnecessary litigation.

Section 7. Amends s. 627.732, F.S., to define "claimant" and "No-Fault Law" within the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7407, F.S.). "Claimant" means the person, organization, or entity seeking benefits, including all assignees. Medical providers that accept an

assignment of benefits from the insured will be claimants under the No-Fault Law and subject to all statutory provisions related to a claimant under the law.

Section 8. Amends s. 627.736, F.S., which contains the statutory provisions governing the provision of Personal Injury Protection insurance coverage. The bill makes numerous revisions, which are detailed and explained herein.

Benefits – No-Fault Preferred Provider Networks [s. 627.736(10), F.S.]

Current law authorizes insurers to contract with licensed health care providers to provide PIP benefits and offer insureds insurance policies containing a "preferred provider" (PPO) option. However, if the insured uses an "out-of-network" provider the insurer must tender reimbursement for such medical benefits as required by the No-Fault Law. The current PPO option does little to reduce PIP costs because there is no incentive for the insured to utilize network providers and thus little incentive for medical providers to contract with the PIP insurer. Additionally, many motor vehicle insurance carriers lack the expertise to create the medical provider network necessary to offer a preferred provider option.

The bill modifies the no-fault preferred provider option by authorizing insurers to provide a premium discount to an insured that selects a policy that reimburses medical benefits from a preferred provider. If a premium discount is provided, the insurer may restrict reimbursement of non-emergency services to members of the preferred provider network unless there are no network providers within 15 miles of the insured's place of residence. The insurer may contract with a health insurer to use an existing preferred provider network, with any other arrangement subject to OIR approval.

Assignment of Benefits [s. 627.736(7)(b), F.S.]

The bill states that a medical provider that accepts an assignment of no-fault benefits from an insured, the medical provider and the insured must comply with all terms of the policy and cooperate under the policy, including submitting to an examination under oath (EUO). Compliance is a condition precedent to recovering benefits under the no-fault law.

Provider Billing Submissions – Notice of Licensure Compliance [s. 627.736(1)(a), F.S.]

A clinic or entity that initially submits a PIP claim to an insurer must include a sworn affidavit that documents that the entity or clinic is eligible to receive reimbursement for the treatment of bodily injuries covered by PIP insurance. The following entities must execute the affidavit:

- An entity that is wholly owned by one or more licensed physicians, chiropractors, or dentists or by the spouse, parent, child, or sibling of such medical practitioners.
- Wholly owned by a hospital or hospitals.
- A licensed health care clinic.

The affidavit must be executed on a form adopted by the DFS. If the entity or clinic changes ownership, a new sworn affidavit must be provided to the insurer within 10 days.

Provider Billing Submissions – Proper Submission of Billing Required for Insurer to Have Notice [s. 627.736(6)(d), F.S.]

The bill specifies that the insurer does not have notice of the amount of covered loss or medical bills unless the statements and bills are submitted on an approved form, follow the proper coding requirements, and contain the professional license number of the provider. The remaining portions of statements and bills must be properly completed in their entirety. Current law contains a less stringent standard requiring bills and statements to be properly completed in their entirety "as to all material provisions, with all relevant information being provided therein."

Section 627.736(6)(c), F.S., generally requires health care providers to submit a statement of charges within 35 days of when the treatment was rendered. If a provider fails to submit the billing within the time frame, the insurer is not required to provide payment. Accordingly, if a provider fails to meet the bill's requirement to property submit a bill, the insurer will not be considered to have notice of the bill and the provider may be unable to obtain reimbursement for such services.

Provider Billing Submissions – Initial Disclosure Form and Patient Treatment Log [s. 627.736(6)(e), F.S.]

Current law requires a medical provider providing treatment for bodily injury covered by PIP insurance to obtain at the initial treatment a disclosure form of the insured's rights that details the treatment to be provided and is signed by the injured person and subsequently countersigned by the injured person verifying that the treatment was rendered. The disclosure and acknowledgement form is not required for emergency services or for ambulance transport and treatment. For subsequent treatments, the provider must maintain a patient log of services rendered in chronological order.

The bill states that the insurer does not have notice of the amount of a covered loss or medical bills unless the original completed disclosure and acknowledgement form is provided to the insurer with the countersignature of the insured and accurately describes the services rendered as required by s. 627.736(6)(e)1.a., F.S. The services rendered must be described on the form in a in a manner readable by the insured; listing billing codes is not allowed. The provider must determine whether the insured can read the disclosure. If not, the provider must verify, under penalty of perjury, that the services were verbally explained to the insured.

The provider must provide copies of the patient log within 30 days after receiving a written request from the insurer. If the provider does not maintain a patient log, the treatment is unlawful and noncompensable. The patient log must describe subsequent services rendered in readable language; listing billing codes is not allowed.

Claim Payments – PIP Fee Schedule [s. 627.736(6)(a)2., F.S.]

The bill clarifies the Medicare fee schedule in effect of January 1 will be the PIP fee schedule for the entire calendar year.

Claim Payments – Reasonable Proof [s. 627.736(4)(d), F.S.]

Under current law, a claims payment is not overdue if the insurer has reasonable proof that it is not responsible for payment. "Reasonable proof" is not defined in statute. The bill states that "reasonable proof" may be defined in the insurance policy and says an insurer may request information that will aid it in its claim investigation.

Insurer Investigation of Possible Fraudulent Insurance Acts [s. 627.736(4)(d), F.S.]

The 30-day period for payment is tolled during the insurer's investigation of a fraudulent insurance act, as defined in s. 626.989, F.S., for any portion of a claim for which the insurer has a reasonable belief that a fraudulent insurance act has been committed. The insurer must notify that claimant in writing that it is investigating a fraudulent insurance act within 30 days after the date the insurer has a reasonable belief the act was committed. The insurer must pay or deny the claim within 120 days.

Benefits are not due to a claimant who submits a false or misleading statement, document, record, bill or information or otherwise commits or attempts to commit a fraudulent insurance act as defined in s. 626.989, F.S. The claimant is not entitled to any PIP benefits regardless of whether a portion of the claim is legitimate. The insurer may recover sums previously paid to such claimants and bring a common law and statutory cause of action against the claimant if the fraud is admitted to in a sworn statement or established in court. Insurance fraud voids all coverage arising for the claim and all claims for attorneys fees, regardless of whether a portion of the claim is legitimate.

The insurer may recover any benefits or attorney's fees paid before the discovery of fraud. The paragraph does not preclude or limit the insurer's right to deny a claim on other evidence of fraud and to prove a claim or defense of fraud under common law. The injured party is not liable for fraudulent acts committed by a physician, hospital, clinic, or other medical institution. The provider not bill the insured or injured party for charges that are unpaid for failure to comply with the prohibition against false statements or fraudulent insurance acts in paragraph (j).

Insurer Investigations – Records Review [s. 627.736(5), F.S.]

The bill states that the insurer had the right and duty to reasonably investigate the claim. As part of the insurer's claim investigation, it may require the insured, claimant, or medical provider to provide copies of treatment and examination records for review by a physician retained by the insurer. The insurer's choice of physician to conduct the records review is not limited by the physician's practice area or licensing chapter. The records review tolls the 30-day period for payment from the date the insurer sends a request for treatment records to the date the insurer receives the treatment records.

Insurer Investigations – Examinations Under Oath [s. 627.736(7)(b), F.S.]

A medical provider that accepts an assignment of benefits must submit to an examination under oath upon the request of the insurer. The provider must produce the persons having the most knowledge of the issues identified by the insurer in the EUO request. All claimants (the person

receiving treatment and the provider) must produce and provide for inspection all reasonably obtainable documents requested by the insurer. The EUO may be recorded by audio, video, or court reporter. Unreasonably requesting EUOs as a general practice is an unfair or deceptive trade practice.

Insurer Investigations – Mental & Physical Examination of Insured [s. 627.736(8), F.S.]

Current law authorizes the insurer to require an injured person to submit to a mental or physical examination whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future PIP insurance benefits. The bill specifies that the insurer is not liable for PIP benefits incurred after the day the insurer first requested an examination if the injured person unreasonably refuses to submit to an examination. The bill also creates a rebuttable presumption that the injured party's failure to appear for an examination was unreasonable.

The provision is intended to reverse the Florida Supreme Court's decision in *Custer Medical Center v. United Automobile Insurance Company*, 53 Fla. L. Weekly S640 (Fla. 2010). In Custer, the Court determined that the insurer must provide evidence that an insured's failure to appear (3 times) for a scheduled medical examination pursuant to s. 627.736(7), F.S., is unreasonable. Because an insured may reasonably refuse to attend a medical examination, the insured's failure to attend the medical examination does not establish that it was unreasonable. Under the *Custer* decision, the insurer cannot prevail on a summary judgment motion on the issue and instead must proffer evidence that the refusal was unreasonable.

Insurer Investigations – On-Site Inspection of Medical Provider [s. 627.736(7)(b), F.S.]

The bill authorizes each insurer to conduct an on-site physical review and examination of the treatment location, treatment apparatuses, diagnostic devices, and medical equipment used for services rendered within 10 days of the insurer's request.

Claim Denial – Grounds for Denying a PIP Claim or Refusing a Provider Billing [s. 627.736(5), F.S.]

The bill specifies grounds for denying or reducing a claim based upon specified acts of the insured, claimant, or medical provider. The insurer may deny a claim or reduce reimbursement if:

- The medical provider fails to maintain adequate records that would allow the insurer to obtain a records review.
- The insured, claimant, or medical provider fails to comply with the statutory requirements for a records review.
- The insured, claimant, or medical provider fails to cooperate in the insurer's investigation.
- The insured, claimant, or medical provider commits a fraud or material misrepresentation.

The claimant may not file suit:

- Until the records review is completed;

- If the claimant fails to cooperate with the insurer's claim investigation; or
- The claimant commits fraud or makes a material misrepresentation.

Under current law, subsection (6) specifies when the insurer or insured is not required to pay a claim or charges. The bill provides that the insurer or insured is not required to make a payment if the insured has not countersigned the billing forms and patient logs. The bill also states the insurer need not pay a bill or statement that does not comply with the billing requirements of subsections (c), (d), or (e). Subsection (c) generally requires the provider to submit a statement of charges to the insurer within 35 days of providing treatment. Subsection (d) requires the use of specified forms and practice codes when submitting a bill to the insurer. Subsection (e) directs the provider to require the insured person to execute a signed disclosure form during the initial treatment and to obtain the patient's countersignature on a treatment log that describes subsequent treatments.

Claim Denial – Insurer's Itemized Specification of Reduced or Denied Benefits [s. 627.736(4)(c), F.S.]

The bill states that an insurer does not waive any ground for rejecting an invalid claim when it fails to send an itemized specification of each portion of a claim denied or for which it reduced reimbursement. Current law requires an insurer that denies or only pays a portion of a PIP claim to provide an itemized specification of each item the insurer declined to pay or denied. The itemized specification includes information the insurer wants the claimant to consider related to the medical necessity of the treatment or to explain why the insurer was reasonable in reducing the charge, provided the information does not limit the introduction of evidence at trial.

Demand Letters [s. 627.736(11), F.S.]

Under current law, the claimant must provide a written demand letter specifying the PIP benefits and amounts that the claimant asserts are due under the policy prior to filing suit. If the insurer pays the overdue claim specified in the demand letter with interest and a 10 percent penalty, the claimant may not file suit. The bill modifies the demand letter requirement as follows:

- The claimant filing suit must submit the demand letter.
- A demand letter that does not meet the requirements of s. 627.736(11), F.S., or is sent during the pendency of a lawsuit is defective.
    - A defective demand letter cannot be cured unless the court abates the action or the claimant voluntarily dismisses the action.
    - If the insurer pays the benefits during abatement or dismissal, the insurer is not liable for attorney's fees.
- If the insurer pays in response to a demand letter and the claimant disputes the amount paid, the claimant must send a second demand letter stating the exact amount the claimant believes the insurer owes and why the amount paid is incorrect. The insurer then has 10 additional days after receiving the second demand letter to issue any additional payment that is owed.
- Demand letters may not be used to request record production from the insurer.
- Removes the requirement that a demand letter involving future treatment must include the insurer's notice of withdrawing payment for future treatment. Under current law, the insurer

may withdraw patient for a treating physician if the insurer retains a physician under that performs a mental or physical examination of the patient pursuant to s. 627.736(7), F.S., and the physician reports that the treatment is not reasonable, related, or necessary.

Section 9. Amends s. 324.021, F.S., by making technical, conforming changes to the definition of "motor vehicle" in the financial responsibility law.

Section 10. Amends s. 456.057(2)(k), F.S., by making a technical conforming change to a statutory reference.

Section 11. Amends s. 627.7401(1)(b), F.S., by making technical conforming changes to statutory references.

Section 12. Amends s. 817.234(7)(c), F.S., by making a technical conforming change to a statutory reference.

Section 13. The act is effective July 1, 2011.

Other Potential Implications:

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:

To the extent that the bill's provisions are effective in reducing motor vehicle insurance fraud, policyholders will benefit through a reduction in rates for such insurance.

C. Government Sector Impact:

The Fight Auto Fraud direct support organization may increase funding to the Division of Insurance Fraud and other law enforcement agencies to combat motor vehicle insurance fraud.

The Department of Highway Safety and Motor Vehicles states that the requirement to utilize the long-form traffic crash report when passengers are involved in an accident or there are indications that a party to the accident is experiencing pain or discomfort will create additional costs for the department. Based on historical trends, this change could increase the number of long form crash reports received by the department by approximately 90,000 per year. In 2009, the department received 76,258 short form reports that included one or more passengers involved in the accident. Based on estimates and the department's current contract for processing crash reports, the new requirements could cost the department to process the additional reports an estimated $104,687 per year. The department further estimates an additional 45,000 hours per year of time would be needed by officers of the state to complete the long form as opposed to the time it takes to complete the shot form.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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 Banking and Insurance Committee

BILL:	SB 1826
INTRODUCER:	Senator Hays
SUBJECT:	Workers' Compensation
DATE:	March 25, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Arzillo	Burgess	BI	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

The bill removes outdated and obsolete language relating to workers' compensation under ch. 627, F.S. The bill repeals obsolete language creating a workers' compensation administrator that has not been filled within the Office of Insurance Regulation (OIR). The bill also removes outdated language for rerating workers' compensation policies to conform to the tier system created in 2004.

This bill amends the following section of the Florida Statutes: 627.312. The bill repeals the following section of the Florida Statutes: 627.092.

II. Present Situation:

Workers' Compensation Administrator

Section 627.092, F.S. creates the position of Workers' Compensation Administrator within the OIR to monitor insurance company compliance with workers' compensation laws. Currently, OIR does not have an employee designated as the Workers' Compensation Administrator because the Department of Financial Services (DFS) is responsible for overall monitoring and auditing of the performance of workers' compensation insurance companies.[1]

Florida Workers' Compensation Joint Underwriting Association (FWCJUA)

The FWCJUA was created in 1993 and began writing claims on January 1, 1994. The FWCJUA is an insurer of last resort, which provides workers' compensation insurance for those employers who cannot obtain it in the private market. Until July 2003, the FWCJUA had three rating plans

[1] *See* ch. 440, F.S.

for various classifications of risk.[2] All three plans had to maintain actuarially sound rates but the rate charged varied depending on the plan, in accordance with the risk characteristics of the employers obtaining workers' compensation insurance.

In 2003, the Legislature established Subplan D within the FWCJUA. This Subplan provided workers' compensation coverage for small employers, with 15 or fewer employees, and charitable organizations. However, rates for Subplan D were capped as a percentage over the voluntary market rates and were not required to be actuarially sound.[3] Consequently, in 2004, Subplan D generated a substantial deficit. In order to fix the deficit, employers in Subplan D were additionally assessed.

In response, in 2004, the Legislature created legislation to defray Subplan D before the employers in the Subplan were assessed.[4] The changes were meant to reduce and eliminate the deficit in Subplan D and to ensure that no future deficits in the FWCJUA occurred. Therefore, the employers in Subplan D were not assessed for the Subplan D deficit.

In addition to funding Subplan D, the Legislature created a three-tier rating system to replace the subplan rating system. The tiers better defined employer risk to ensure the employers were placed in the correct risk pool.[5] The new rating system provides the FWCJUA with a premium better associated with the employers' risk.[6]

Section 627.312(2), F.S. was enacted to guide the transition from the Subplan rating system to the tier rating system by the FWCJUA. This section required FWCJUA policies in effect between May 28, 2004[7] and June 30, 2004[8] to be transferred from the subplan rating system to the tier rating system and rerated for premium purposes.[9]

III. Effect of Proposed Changes:

Section 1 repeals s. 627.092, F.S., because the OIR does not monitor or audit workers' compensation insurance companies and does not employ a Workers' Compensation Administrator. The DFS maintains the Bureau of Monitoring and Audit within the Division of Workers' Compensation which performs the functions set out for the Workers' Compensation Administrator in s. 627.092, F.S. Therefore, the bill repeals obsolete language.

Section 2 deletes language from s. 627.312, F.S., because it is obsolete. Section 627.312(2), F.S. was created to transition the workers' compensation insurance plans under the FWCJUA from the Subplan system to the tier system. The law required the that all plans in effect between March 28 and June 30, 2004, were rerated and transferred to the tier system. FWCJUA rerated

[2] The risk ratings were: Subplan A, Subplan B and Subplan C.
[3] Rates for policies in Subplan D were priced at the voluntary market rate with a surcharge not to exceed 25%. However, the surcharge for those organizations exempt from federal income tax under 501(c)(3) was not to exceed 10%.
[4] *See* ch. 2004-266, L.O.F. *See also* HB 1251 (2004).
[5] *See* id.
[6] Each of the tiers are now required to be actuarially sound.
[7] The date HB 1251 (2004) became law.
[8] The date HB 1251 (2004) was enacted.

and transitioned all of its policies by July 1, 2004. Therefore, the bill deletes this obsolete language.

Other Potential Implications:

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:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 627.0655, Florida Statutes, is amended to read:

627.0655 Policyholder ~~loss or expense-related~~ premium discounts.—An insurer or person authorized to engage in the business of insurance in this state may include a discount~~,~~ in the premium charged an insured for any policy, contract, or certificate of insurance if~~, a discount based on the fact that~~ another policy, contract, or certificate of any type has been

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purchased by the insured:

(1) From the same insurer or insurer group;~~,~~

(2) For policies issued or renewed before January 1, 2013, from the Citizens Property Insurance Corporation created under s. 627.351(6) if the same insurance agent is servicing both policies;~~,~~ or

(3) For policies issued or renewed before January 1, 2013, from an insurer that has removed the policy from the Citizens Property Insurance Corporation if the same insurance agent is servicing both policies.

Section 2. Paragraphs (a), (b), (c), (d), (n), (o), (q), (s), (w), (x), (y), (aa), and (ee) of subsection (6) of section 627.351, Florida Statutes, are amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(a)~~1. It is~~ The public purpose of this subsection is to ensure that there is ~~the existence of~~ an orderly market for property insurance for residents ~~Floridians~~ and ~~Florida~~ businesses of this state.

1. The Legislature finds that actual and threatened catastrophic losses to property from hurricanes in this state have caused insurers to be unwilling or unable to provide property insurance coverage to the extent sought and needed. The Legislature declares that it is in the public interest and serves a public purpose that property in this state be adequately insured in order to facilitate the remediation, reconstruction, and replacement of damaged or destroyed property. Such efforts are necessary in order to avoid or reduce negative effects to the public health, safety, and welfare; the

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economy of the state; and the revenues of state and local governments. It is necessary, therefore, to provide property insurance to applicants who are entitled to procure insurance through the voluntary market but who, in good faith, are unable to do so. ~~The Legislature finds that private insurers are unwilling or unable to provide affordable property insurance coverage in this state to the extent sought and needed. The absence of affordable property insurance threatens the public health, safety, and welfare and likewise threatens the economic health of the state. The state therefore has a compelling public interest and a public purpose to assist in assuring that property in the state is insured and that it is insured at affordable rates so as to facilitate the remediation, reconstruction, and replacement of damaged or destroyed property in order to reduce or avoid the negative effects otherwise resulting to the public health, safety, and welfare, to the economy of the state, and to the revenues of the state and local governments which are needed to provide for the public welfare. It is necessary, therefore, to provide affordable property insurance to applicants who are in good faith entitled to procure insurance through the voluntary market but are unable to do so.~~ The Legislature intends, therefore, ~~by this subsection~~ that ~~affordable~~ property insurance be provided and that it continue to be provided, as long as necessary, through Citizens Property Insurance Corporation, a government entity that is an integral part of the state, and that is not a private insurance company. ~~To that end, Citizens Property Insurance Corporation shall strive to increase the availability of affordable property insurance in this state, while achieving efficiencies and~~

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~~economies, and while providing service to policyholders, applicants, and agents which is no less than the quality generally provided in the voluntary market, for the achievement of the foregoing public purposes. Because it is essential for this government entity to have the maximum financial resources to pay claims following a catastrophic hurricane, it is the intent of the Legislature that Citizens Property Insurance Corporation continue to be an integral part of the state and that the income of the corporation be exempt from federal income taxation and that interest on the debt obligations issued by the corporation be exempt from federal income taxation.~~

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

b. Because it is essential that the corporation have the maximum financial resources necessary to pay claims following a catastrophic hurricane, the Legislature also intends that the income of the corporation and interest on the debt obligations issued by the corporation be exempt from federal income taxation.

2. The Residential Property and Casualty Joint Underwriting Association originally created by this statute shall be known~~,~~

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~~as of July 1, 2002,~~ as the Citizens Property Insurance Corporation. The corporation shall provide insurance for residential and commercial property, for applicants who are ~~in good faith~~ entitled, but, in good faith, are unable~~,~~ to procure insurance through the voluntary market. The corporation shall operate pursuant to a plan of operation approved by order of the Financial Services Commission. The plan is subject to continuous review by the commission. The commission may, by order, withdraw approval of all or part of a plan if the commission determines that conditions have changed since approval was granted and that the purposes of the plan require changes in the plan. ~~The corporation shall continue to operate pursuant to the plan of operation approved by the Office of Insurance Regulation until October 1, 2006.~~ For the purposes of this subsection, residential coverage includes both personal lines residential coverage, which consists of the type of coverage provided by homeowner's, mobile home owner's, dwelling, tenant's, condominium unit owner's, and similar policies;~~,~~ and commercial lines residential coverage, which consists of the type of coverage provided by condominium association, apartment building, and similar policies.

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

a. Effective January 1, 2009, a ~~personal lines residential~~ structure that has a dwelling replacement cost of $2 million or more, or a single condominium unit that has a combined dwelling and contents ~~content~~ replacement cost of $2 million or more is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2008, may continue to

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be covered by the corporation until the end of the policy term. However, such dwellings ~~that are insured by the corporation and become ineligible for coverage due to the provisions of this subparagraph~~ may reapply and obtain coverage if the property owner provides the corporation with a sworn affidavit from one or more insurance agents, on a form provided by the corporation, stating that the agents have made their best efforts to obtain coverage and that the property has been rejected for coverage by at least one authorized insurer and at least three surplus lines insurers. If such conditions are met, the dwelling may be insured by the corporation for up to 3 years, after which time the dwelling is ineligible for coverage. ~~The office shall approve the method used by the corporation for valuing the dwelling replacement cost for the purposes of this subparagraph. If a policyholder is insured by the corporation prior to being determined to be ineligible pursuant to this subparagraph and such policyholder files a lawsuit challenging the determination, the policyholder may remain insured by the corporation until the conclusion of the litigation.~~

b. Effective January 1, 2012, a structure that has a dwelling replacement cost of $1 million or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $1 million or more is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2011, may continue to be covered by the corporation only until the end of the policy term.

c. Effective January 1, 2014, a structure insured in the personal lines account of the corporation that has a dwelling replacement cost of $750,000 or more, or a single condominium

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unit that has a combined dwelling and contents replacement cost of $750,000 or more is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2013, may continue to be covered by the corporation until the end of the policy term.

d. Effective January 1, 2016, a structure insured in the personal lines account of the corporation that has a dwelling replacement cost of $500,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $500,000 or more is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2015, may continue to be covered by the corporation until the end of the policy term.

4. Any structure for which a permit for construction is obtained on or after June 1, 2011, seaward of the coastal construction control line established pursuant to s. 161.053, is not eligible for coverage by the corporation.

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

5. Effective January 1, 2009, a personal lines residential structure that is located in the "wind-borne debris region," as defined in s. 1609.2, International Building Code (2006), and


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that has an insured value on the structure of $750,000 or more is not eligible for coverage by the corporation unless the structure has opening protections as required under the Florida Building Code for a newly constructed residential structure in that area. A residential structure shall be deemed to comply with ~~the requirements of~~ this subparagraph if it has shutters or opening protections on all openings and if such opening protections complied with the Florida Building Code at the time they were installed.

6. In recognition of the corporation's status as a government entity, policies issued by the corporation must include a provision stating that as a condition of coverage with the corporation, policyholders may not engage the services of a public adjuster to represent the policyholder with respect to any claim filed under a policy issued by the corporation until after the corporation has tendered an offer with respect to such claim. For any claim filed under any policy of the corporation, a public adjuster may not request payment or be paid, on a contingency basis or based in any way, directly or indirectly, on a percentage of the claim amount, and may be paid only a reasonable hourly fee based on the actual hours of work performed, subject to a maximum of 5 percent of the additional amount actually paid over the amount which was originally offered by the corporation for any one claim.

(b)1. All insurers authorized to write one or more subject lines of business in this state are subject to assessment by the corporation and, for the purposes of this subsection, are referred to collectively as "assessable insurers." Insurers writing one or more subject lines of business in this state


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pursuant to part VIII of chapter 626 are not assessable insurers, but insureds who procure one or more subject lines of business in this state pursuant to part VIII of chapter 626 are subject to assessment by the corporation and are referred to collectively as "assessable insureds." An ~~authorized~~ insurer's assessment liability begins ~~shall begin~~ on the first day of the calendar year following the year in which the insurer was issued a certificate of authority to transact insurance for subject lines of business in this state and terminates ~~shall terminate~~ 1 year after the end of the first calendar year during which the insurer no longer holds a certificate of authority to transact insurance for subject lines of business in this state.

2.a. All revenues, assets, liabilities, losses, and expenses of the corporation shall be divided into three separate accounts as follows:

(I) A personal lines account for personal residential policies issued by the corporation, or issued by the Residential Property and Casualty Joint Underwriting Association and renewed by the corporation, which provides basic ~~that provide comprehensive,~~ multiperil coverage on risks that are not located in areas eligible for coverage by ~~in~~ the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002, and for ~~such~~ policies that do not provide coverage for the peril of wind on risks that are located in such areas;

(II) A commercial lines account for commercial residential and commercial nonresidential policies issued by the corporation, or issued by the Residential Property and Casualty Joint Underwriting Association and renewed by the corporation, which provides ~~that provide~~ coverage for basic property perils

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on risks that are not located in areas eligible for coverage by ~~in~~ the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002, and for ~~such~~ policies that do not provide coverage for the peril of wind on risks that are located in such areas; and

(III) A high-risk account for personal residential policies and commercial residential and commercial nonresidential property policies issued by the corporation or transferred to the corporation, which provides ~~that provide~~ coverage for the peril of wind on risks that are located in areas eligible for coverage by ~~in~~ the Florida Windstorm Underwriting Association as those areas were defined on January 1, 2002. The corporation may offer policies that provide multiperil coverage and the corporation shall continue to offer policies that provide coverage only for the peril of wind for risks located in areas eligible for coverage in the high-risk account. In issuing multiperil coverage, the corporation may use its approved policy forms and rates for the personal lines account. An applicant or insured who is eligible to purchase a multiperil policy from the corporation may purchase a multiperil policy from an authorized insurer without prejudice to the applicant's or insured's eligibility to prospectively purchase a policy that provides coverage only for the peril of wind from the corporation. An applicant or insured who is eligible for a corporation policy that provides coverage only for the peril of wind may elect to purchase or retain such policy and also purchase or retain coverage excluding wind from an authorized insurer without prejudice to the applicant's or insured's eligibility to prospectively purchase a policy that provides multiperil

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coverage from the corporation. ~~It is the goal of the Legislature that there would be an overall average savings of 10 percent or more for a policyholder who currently has a wind-only policy with the corporation, and an ex-wind policy with a voluntary insurer or the corporation, and who then obtains a multiperil policy from the corporation.~~ It is the intent of the Legislature that the offer of multiperil coverage in the high-risk account be made and implemented in a manner that does not adversely affect the tax-exempt status of the corporation or creditworthiness of or security for currently outstanding financing obligations or credit facilities of the high-risk account, the personal lines account, or the commercial lines account. ~~The high-risk account must also include quota share primary insurance under subparagraph (c)2.~~ The area eligible for coverage under the high-risk account also includes the area within Port Canaveral, which is bordered on the south by the City of Cape Canaveral, bordered on the west by the Banana River, and bordered on the north by Federal Government property.

b. The three separate accounts must be maintained as long as financing obligations entered into by the Florida Windstorm Underwriting Association or Residential Property and Casualty Joint Underwriting Association are outstanding, in accordance with the terms of the corresponding financing documents. If ~~When~~ the financing obligations are no longer outstanding, ~~in accordance with the terms of the corresponding financing documents,~~ the corporation may use a single account for all revenues, assets, liabilities, losses, and expenses of the corporation. Consistent with ~~the requirement of~~ this subparagraph and prudent investment policies that minimize the

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cost of carrying debt, the board shall exercise its best efforts to retire existing debt or ~~to~~ obtain the approval of necessary parties to amend the terms of existing debt, so as to structure the most efficient plan to consolidate the three separate accounts into a single account.

c. Creditors of the Residential Property and Casualty Joint Underwriting Association and of the accounts specified in sub-sub-subparagraphs a.(I) and (II) may have a claim against, and recourse to, those ~~the~~ accounts ~~referred to in sub-sub-subparagraphs a.(I) and (II)~~ and ~~shall have~~ no claim against, or recourse to, the account referred to in sub-sub-subparagraph a.(III). Creditors of the Florida Windstorm Underwriting Association ~~shall~~ have a claim against, and recourse to, the account referred to in sub-sub-subparagraph a.(III) and ~~shall have~~ no claim against, or recourse to, the accounts referred to in sub-sub-subparagraphs a.(I) and (II).

d. Revenues, assets, liabilities, losses, and expenses not attributable to particular accounts shall be prorated among the accounts.

e. The Legislature finds that the revenues of the corporation are revenues that are necessary to meet the requirements set forth in documents authorizing the issuance of bonds under this subsection.

f. No part of the income of the corporation may inure to the benefit of any private person.

3. With respect to a deficit in an account:

a. After accounting for the ~~Citizens~~ policyholder surcharge imposed under sub-subparagraph i., if ~~when~~ the remaining projected deficit incurred in a particular calendar year is not


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greater than 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year, the entire deficit shall be recovered through regular assessments of assessable insurers under paragraph (q) and assessable insureds.

b. After accounting for the Citizens policyholder surcharge imposed under sub-subparagraph i., when the remaining projected deficit incurred in a particular calendar year exceeds 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year, the corporation shall levy regular assessments on assessable insurers under paragraph (q) and on assessable insureds in an amount equal to the greater of 6 percent of the deficit or 6 percent of the aggregate statewide direct written premium for the subject lines of business for the prior calendar year. Any remaining deficit shall be recovered through emergency assessments under sub-subparagraph d.

c. Each assessable insurer's share of the amount being assessed under sub-subparagraph a. or sub-subparagraph b. must ~~shall~~ be in the proportion that the assessable insurer's direct written premium for the subject lines of business for the year preceding the assessment bears to the aggregate statewide direct written premium for the subject lines of business for that year. The applicable assessment percentage ~~applicable to each assessable insured~~ is the ratio of the amount being assessed under sub-subparagraph a. or sub-subparagraph b. to the aggregate statewide direct written premium for the subject lines of business for the prior year. Assessments levied by the corporation on assessable insurers under sub-subparagraphs a.


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and b. must ~~shall~~ be paid as required by the corporation's plan of operation and paragraph (q). Assessments levied by the corporation on assessable insureds under sub-subparagraphs a. and b. shall be collected by the surplus lines agent at the time the surplus lines agent collects the surplus lines tax required by s. 626.932, and ~~shall be~~ paid to the Florida Surplus Lines Service Office at the time the surplus lines agent pays the surplus lines tax to that ~~the Florida Surplus Lines Service~~ office. Upon receipt of regular assessments from surplus lines agents, the Florida Surplus Lines Service Office shall transfer the assessments directly to the corporation as determined by the corporation.

d. Upon a determination by the board of governors that a deficit in an account exceeds the amount that will be recovered through regular assessments under sub-subparagraph a. or sub-subparagraph b., plus the amount that is expected to be recovered through surcharges under sub-subparagraph i., ~~as to the remaining projected deficit~~ the board ~~shall levy~~, after verification by the office, shall levy emergency assessments~~,~~ for as many years as necessary to cover the deficits, to be collected by assessable insurers and the corporation and collected from assessable insureds upon issuance or renewal of policies for subject lines of business, excluding National Flood Insurance policies. The amount of the emergency assessment collected in a particular year must ~~shall~~ be a uniform percentage of that year's direct written premium for subject lines of business ~~and all accounts of the corporation~~, excluding National Flood Insurance Program policy premiums, as annually determined by the board and verified by the office. For all

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accounts of the corporation, the amount of the emergency assessment levied in a particular year must be a uniform percentage equal to 1 1/2 times the uniform percentage emergency assessment levied on subject lines of business. The office shall verify the arithmetic calculations involved in the board's determination within 30 days after receipt of the information on which the determination was based. Notwithstanding any other provision of law, the corporation and each assessable insurer that writes subject lines of business shall collect emergency assessments from its policyholders without such obligation being affected by any credit, limitation, exemption, or deferment. Emergency assessments levied by the corporation on assessable insureds shall be collected by the surplus lines agent at the time the surplus lines agent collects the surplus lines tax required by s. 626.932 and ~~shall be~~ paid to the Florida Surplus Lines Service Office at the time the surplus lines agent pays the surplus lines tax to that ~~the Florida Surplus Lines Service~~ office. The emergency assessments ~~so~~ collected shall be transferred directly to the corporation on a periodic basis as determined by the corporation and ~~shall be~~ held by the corporation solely in the applicable account. The aggregate amount of emergency assessments levied for an account under this sub-subparagraph in any calendar year may~~, at the discretion of the board of governors,~~ be less than but ~~may~~ not exceed the greater of 10 percent of the amount needed to cover the deficit, plus interest, fees, commissions, required reserves, and other costs associated with financing ~~of~~ the original deficit, or 10 percent of the aggregate statewide direct written premium for subject lines of business and 15 percent for all accounts of the

corporation for the prior year, plus interest, fees, commissions, required reserves, and other costs associated with financing the deficit.

e. The corporation may pledge the proceeds of assessments, projected recoveries from the Florida Hurricane Catastrophe Fund, other insurance and reinsurance recoverables, policyholder surcharges and other surcharges, and other funds available to the corporation as the source of revenue for and to secure bonds issued under paragraph (q), bonds or other indebtedness issued under subparagraph (c)2.~~3.~~, or lines of credit or other financing mechanisms issued or created under this subsection, or to retire any other debt incurred as a result of deficits or events giving rise to deficits, or in any other way that the board determines will efficiently recover such deficits. The purpose of the lines of credit or other financing mechanisms is to provide additional resources to assist the corporation in covering claims and expenses attributable to a catastrophe. As used in this subsection, the term "assessments" includes regular assessments under sub-subparagraph a., sub-subparagraph b., or subparagraph (q)1. and emergency assessments under sub-subparagraph d. Emergency assessments collected under sub-subparagraph d. are not part of an insurer's rates, are not premium, and are not subject to premium tax, fees, or commissions; however, failure to pay the emergency assessment shall be treated as failure to pay premium. The emergency assessments under sub-subparagraph d. shall continue as long as any bonds issued or other indebtedness incurred with respect to a deficit for which the assessment was imposed remain outstanding, unless adequate provision has been made for the

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payment of such bonds or other indebtedness pursuant to the documents governing such bonds or ~~other~~ indebtedness.

f. As used in this subsection for purposes of any deficit incurred on or after January 25, 2007, the term "subject lines of business" means insurance written by assessable insurers or procured by assessable insureds for all property and casualty lines of business in this state, but not including workers' compensation or medical malpractice. As used in this ~~the~~ sub-subparagraph, the term "property and casualty lines of business" includes all lines of business identified on Form 2, Exhibit of Premiums and Losses, in the annual statement required of authorized insurers under ~~by~~ s. 624.424 and any rule adopted under this section, except for those lines identified as accident and health insurance and except for policies written under the National Flood Insurance Program or the Federal Crop Insurance Program. For purposes of this sub-subparagraph, the term "workers' compensation" includes both workers' compensation insurance and excess workers' compensation insurance.

g. The Florida Surplus Lines Service Office shall determine annually the aggregate statewide written premium in subject lines of business procured by assessable insureds and ~~shall~~ report that information to the corporation in a form and at a time the corporation specifies to ensure that the corporation can meet the requirements of this subsection and the corporation's financing obligations.

h. The Florida Surplus Lines Service Office shall verify the proper application by surplus lines agents of assessment percentages for regular assessments and emergency assessments levied under this subparagraph on assessable insureds and ~~shall~~

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assist the corporation in ensuring the accurate, timely collection and payment of assessments by surplus lines agents as required by the corporation.

i. If a deficit is incurred in any account in 2011 ~~2008~~ or thereafter, the board of governors shall levy a ~~Citizens~~ policyholder surcharge against all policyholders of the corporation. ~~for a 12-month period, which~~

(I) The surcharge shall be levied ~~collected at the time of issuance or renewal of a policy,~~ as a uniform percentage of the premium for the policy of up to 15 percent of such premium, which funds shall be used to offset the deficit.

(II) It is the intent of the Legislature that the policyholder's liability for the surcharge attach on the date of the order levying the surcharge. The surcharge is payable upon cancellation or termination of the policy, upon renewal of the policy, or upon issuance of a new policy by the corporation within the first 12 months after the date of the levy or the period of time necessary to fully collect the surcharge amount.

(III) The corporation may not levy any regular assessments under paragraph (q) pursuant to sub-subparagraph a. or sub-subparagraph b. with respect to a particular year's deficit until the corporation has first levied a surcharge under this sub-subparagraph in the full amount authorized by this sub-subparagraph.

(IV) The surcharge is ~~Citizens policyholder surcharges under this sub-subparagraph are~~ not considered premium and is ~~are~~ not subject to commissions, fees, or premium taxes. However, failure to pay the surcharge ~~such surcharges~~ shall be treated as failure to pay premium.


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j. If the amount of any assessments or surcharges collected from corporation policyholders, assessable insurers or their policyholders, or assessable insureds exceeds the amount of the deficits, such excess amounts shall be remitted to and retained by the corporation in a reserve to be used by the corporation, as determined by the board of governors and approved by the office, to pay claims or reduce any past, present, or future plan-year deficits or to reduce outstanding debt.

(c) The ~~plan of operation of the~~ corporation:

1. Must provide ~~for adoption of~~ residential property and casualty insurance policy forms and commercial residential and nonresidential property insurance forms, which ~~forms~~ must be approved by the office before ~~prior to~~ use. The corporation shall adopt and offer only the following policy forms:

a. Standard personal lines policy forms that are similar ~~comprehensive multiperil policies providing full coverage of a residential property equivalent~~ to the coverage provided in the private insurance market under an HO-3, HO-4, or HO-6 policy. The corporation shall cease to offer or renew HO-3 policy forms on December 31, 2012.

b. Basic personal lines policy forms that are policies similar to an HO-8 policy or a dwelling fire policy that provide coverage meeting the requirements of the secondary mortgage market, but which ~~coverage~~ is more limited than the coverage under a standard policy.

c. Commercial lines residential and nonresidential policy forms that are generally similar to the basic perils of full coverage obtainable for commercial residential structures and commercial nonresidential structures in the admitted voluntary


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market.

d. Personal lines and commercial lines residential property insurance forms that cover the peril of wind only. The forms are applicable only to residential properties located in areas eligible for coverage under the high-risk account referred to in sub-subparagraph (b)2.a.

e. Commercial lines nonresidential property insurance forms that cover the peril of wind only. The forms are applicable only to nonresidential properties located in areas eligible for coverage under the high-risk account referred to in sub-subparagraph (b)2.a.

f. The corporation may adopt variations of the policy forms listed in sub-subparagraphs a.-e. which ~~that~~ contain more restrictive coverage.

~~2.a. Must provide that the corporation adopt a program in which the corporation and authorized insurers enter into quota share primary insurance agreements for hurricane coverage, as defined in s. 627.4025(2)(a), for eligible risks, and adopt property insurance forms for eligible risks which cover the peril of wind only. As used in this subsection, the term:~~

~~(I) "Quota share primary insurance" means an arrangement in which the primary hurricane coverage of an eligible risk is provided in specified percentages by the corporation and an authorized insurer. The corporation and authorized insurer are each solely responsible for a specified percentage of hurricane coverage of an eligible risk as set forth in a quota share primary insurance agreement between the corporation and an authorized insurer and the insurance contract. The responsibility of the corporation or authorized insurer to pay~~


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~~its specified percentage of hurricane losses of an eligible risk, as set forth in the quota share primary insurance agreement, may not be altered by the inability of the other party to the agreement to pay its specified percentage of hurricane losses. Eligible risks that are provided hurricane coverage through a quota share primary insurance arrangement must be provided policy forms that set forth the obligations of the corporation and authorized insurer under the arrangement, clearly specify the percentages of quota share primary insurance provided by the corporation and authorized insurer, and conspicuously and clearly state that neither the authorized insurer nor the corporation may be held responsible beyond its specified percentage of coverage of hurricane losses.~~

~~(II) "Eligible risks" means personal lines residential and commercial lines residential risks that meet the underwriting criteria of the corporation and are located in areas that were eligible for coverage by the Florida Windstorm Underwriting Association on January 1, 2002.~~

~~b. The corporation may enter into quota share primary insurance agreements with authorized insurers at corporation coverage levels of 90 percent and 50 percent.~~

~~c. If the corporation determines that additional coverage levels are necessary to maximize participation in quota share primary insurance agreements by authorized insurers, the corporation may establish additional coverage levels. However, the corporation's quota share primary insurance coverage level may not exceed 90 percent.~~

~~d. Any quota share primary insurance agreement entered into between an authorized insurer and the corporation must provide~~


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~~for a uniform specified percentage of coverage of hurricane losses, by county or territory as set forth by the corporation board, for all eligible risks of the authorized insurer covered under the quota share primary insurance agreement.~~

~~e. Any quota share primary insurance agreement entered into between an authorized insurer and the corporation is subject to review and approval by the office. However, such agreement shall be authorized only as to insurance contracts entered into between an authorized insurer and an insured who is already insured by the corporation for wind coverage.~~

~~f. For all eligible risks covered under quota share primary insurance agreements, the exposure and coverage levels for both the corporation and authorized insurers shall be reported by the corporation to the Florida Hurricane Catastrophe Fund. For all policies of eligible risks covered under quota share primary insurance agreements, the corporation and the authorized insurer shall maintain complete and accurate records for the purpose of exposure and loss reimbursement audits as required by Florida Hurricane Catastrophe Fund rules. The corporation and the authorized insurer shall each maintain duplicate copies of policy declaration pages and supporting claims documents.~~

~~g. The corporation board shall establish in its plan of operation standards for quota share agreements which ensure that there is no discriminatory application among insurers as to the terms of quota share agreements, pricing of quota share agreements, incentive provisions if any, and consideration paid for servicing policies or adjusting claims.~~

~~h. The quota share primary insurance agreement between the corporation and an authorized insurer must set forth the~~

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~~specific terms under which coverage is provided, including, but not limited to, the sale and servicing of policies issued under the agreement by the insurance agent of the authorized insurer producing the business, the reporting of information concerning eligible risks, the payment of premium to the corporation, and arrangements for the adjustment and payment of hurricane claims incurred on eligible risks by the claims adjuster and personnel of the authorized insurer. Entering into a quota sharing insurance agreement between the corporation and an authorized insurer shall be voluntary and at the discretion of the authorized insurer.~~

2.~~3.~~ May ~~provide that the corporation may~~ employ or otherwise contract with individuals or other entities to provide administrative or professional services ~~that may be appropriate to effectuate the plan~~.

a. The corporation may ~~shall have the power to~~ borrow funds~~,~~ by issuing bonds or by incurring other indebtedness, and shall have other powers reasonably necessary to effectuate the requirements of this subsection, including, without limitation, the power to issue bonds and incur other indebtedness in order to refinance outstanding bonds or other indebtedness. The corporation may~~, but is not required to,~~ seek judicial validation of its bonds or other indebtedness under chapter 75. The corporation may issue bonds or incur other indebtedness, or have bonds issued on its behalf by a unit of local government pursuant to subparagraph (q)2., in the absence of a hurricane or other weather-related event, upon a determination by the corporation, subject to approval by the office, that such action would enable it to efficiently meet the financial obligations of

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the corporation and that such financings are reasonably necessary to effectuate the requirements of this subsection. The corporation may ~~is authorized to~~ take all actions needed to facilitate tax-free status for ~~any~~ such bonds or indebtedness, including formation of trusts or other affiliated entities. The corporation may ~~shall have the authority to~~ pledge assessments, projected recoveries from the Florida Hurricane Catastrophe Fund, other reinsurance recoverables, market equalization and other surcharges, and other funds available to the corporation as security for bonds or other indebtedness. In recognition of s. 10, Art. I of the State Constitution, prohibiting the impairment of obligations of contracts, it is the intent of the Legislature that no action be taken whose purpose is to impair any bond indenture or financing agreement or any revenue source committed by contract to such bond or other indebtedness.

b. To ensure that the corporation is operating in an efficient and economic manner while providing quality service to policyholders, applicants, and agents, the board shall commission an independent third-party consultant having expertise in insurance company management or insurance company management consulting to prepare a report and make recommendations on the relative costs and benefits of outsourcing various policy issuance and service functions to private servicing carriers or entities performing similar functions in the private market for a fee, rather than performing such functions in-house. In making such recommendations, the consultant shall consider how other residual markets, both in this state and around the country, outsource appropriate functions or use servicing carriers to

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better match expenses with revenues that fluctuate based on a widely varying policy count. The report must be completed by February 1, 2012. Upon receiving the report, the board shall develop a plan to implement the report and submit the plan to the Financial Services Commission. The commission has 30 days after receiving the plan to review and make additions or corrections, if any. Upon the commission's approval of the plan, the board shall begin implementing the plan by January 1, 2013.

3.~~4.a.~~ Must ~~require that the corporation~~ operate subject to the supervision and approval of a board of governors consisting of eight individuals who are residents of this state, from different geographical areas of this state.

a. The Governor, the Chief Financial Officer, the President of the Senate, and the Speaker of the House of Representatives shall each appoint two members of the board. At least one of the two members appointed by each appointing officer must have demonstrated expertise in insurance, and be within the scope of the exemption provided in s. 112.313(7)(b). The Chief Financial Officer shall designate one of the appointees as chair. All board members serve at the pleasure of the appointing officer. All members of the board ~~of governors~~ are subject to removal at will by the officers who appointed them. All board members, including the chair, must be appointed to serve for 3-year terms beginning annually on a date designated by the plan. However, for the first term beginning on or after July 1, 2009, each appointing officer shall appoint one member of the board for a 2-year term and one member for a 3-year term. A ~~Any~~ board vacancy shall be filled for the unexpired term by the appointing officer. The Chief Financial Officer shall appoint a technical

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advisory group to provide information and advice to the board ~~of governors~~ in connection with the board's duties under this subsection. The executive director and senior managers of the corporation shall be engaged by the board and serve at the pleasure of the board. Any executive director appointed on or after July 1, 2006, is subject to confirmation by the Senate. The executive director is responsible for employing other staff as the corporation may require, subject to review and concurrence by the board.

b. The board shall create a Market Accountability Advisory Committee to assist the corporation in developing awareness of its rates and its customer and agent service levels in relationship to the voluntary market insurers writing similar coverage, and to provide advice on issues regarding agent appointments and compensation.

(I) The members of the advisory committee shall consist of the following 11 persons, one of whom must be elected chair by the members of the committee: four representatives, one appointed by the Florida Association of Insurance Agents, one by the National ~~Florida~~ Association of Insurance and Financial Advisors-Florida ~~Advisors~~, one by the Professional Insurance Agents of Florida, and one by the Latin American Association of Insurance Agencies; three representatives appointed by the insurers with the three highest voluntary market share of residential property insurance business in the state; one representative from the Office of Insurance Regulation; one consumer appointed by the board who is insured by the corporation at the time of appointment to the committee; one representative appointed by the Florida Association of Realtors;

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and one representative appointed by the Florida Bankers Association. All members shall be appointed to ~~must serve for~~ 3-year terms and may serve for consecutive terms.

(II) The committee shall report to the corporation at each board meeting on insurance market issues which may include rates and rate competition with the voluntary market; service, including policy issuance, claims processing, and general responsiveness to policyholders, applicants, and agents; and matters relating to depopulation, producer compensation, or agency agreements.

4.~~5.~~ Must provide a procedure for determining the eligibility of a risk for coverage, as follows:

a. Subject to ~~the provisions of~~ s. 627.3517, with respect to personal lines residential risks, if the risk is offered coverage from an authorized insurer at the insurer's approved rate under ~~either~~ a standard policy including wind coverage or, if consistent with the insurer's underwriting rules as filed with the office, a basic policy including wind coverage, for a new application to the corporation for coverage, the risk is not eligible for any policy issued by the corporation ~~unless the premium for coverage from the authorized insurer is more than 15 percent greater than the premium for comparable coverage from the corporation~~. If the risk is not able to obtain ~~any~~ such offer, the risk is eligible for ~~either~~ a standard policy including wind coverage or a basic policy including wind coverage issued by the corporation; however, if the risk could not be insured under a standard policy including wind coverage regardless of market conditions, the risk is ~~shall be~~ eligible for a basic policy including wind coverage unless rejected under


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subparagraph 9. ~~8.~~ Notwithstanding these limitations, an application for coverage having an effective date before January 1, 2015, is eligible for coverage by the corporation if the premium for coverage from an authorized insurer exceeds the premium from the corporation by more than 25 percent. ~~However, with regard to a policyholder of the corporation or a policyholder removed from the corporation through an assumption agreement until the end of the assumption period, the policyholder remains eligible for coverage from the corporation regardless of any offer of coverage from an authorized insurer or surplus lines insurer.~~ The corporation shall determine the type of policy to be provided on the basis of objective standards specified in the underwriting manual and based on generally accepted underwriting practices.

(I) If the risk accepts an offer of coverage through the market assistance plan or ~~an offer of coverage~~ through a mechanism established by the corporation before a policy is issued to the risk by the corporation or during the first 30 days of coverage by the corporation, and the producing agent who submitted the application to the plan or to the corporation is not currently appointed by the insurer, the insurer shall:

(A) Pay to the producing agent of record of the policy, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent of record of the policy to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the greater of

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the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

(II) If ~~When~~ the corporation enters into a contractual agreement for a take-out plan, the producing agent of record of the corporation policy is entitled to retain any unearned commission on the policy, and the insurer shall:

(A) Pay to the producing agent ~~of record of the corporation policy~~, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent ~~of record of the corporation policy~~ to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the greater of the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

b. Subject to s. 627.3517, with respect to commercial lines residential risks, ~~for a new application to the corporation for coverage,~~ if the risk is offered coverage under a policy including wind coverage from an authorized insurer at its approved rate, the risk is not eligible for a ~~any~~ policy issued

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by the corporation ~~unless the premium for coverage from the authorized insurer is more than 15 percent greater than the premium for comparable coverage from the corporation~~. If the risk is not able to obtain any such offer, the risk is eligible for a policy including wind coverage issued by the corporation. Notwithstanding these limitations, an application for coverage having an effective date before January 1, 2015, is eligible for coverage by the corporation if the premium for coverage from an authorized insurer exceeds the premium from the corporation by more than 25 percent. ~~However, with regard to a policyholder of the corporation or a policyholder removed from the corporation through an assumption agreement until the end of the assumption period, the policyholder remains eligible for coverage from the corporation regardless of any offer of coverage from an authorized insurer or surplus lines insurer.~~

(I) If the risk accepts an offer of coverage through the market assistance plan or ~~an offer of coverage~~ through a mechanism established by the corporation before a policy is issued to the risk by the corporation or during the first 30 days of coverage by the corporation, and the producing agent who submitted the application to the plan or the corporation is not currently appointed by the insurer, the insurer shall:

(A) Pay to the producing agent ~~of record of the policy~~, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent ~~of record of the policy~~ to continue servicing the policy for at least ~~a period of~~

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~~not less than~~ 1 year and offer to pay the agent the greater of the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

(II) If ~~When~~ the corporation enters into a contractual agreement for a take-out plan, the producing agent of record of the corporation policy is entitled to retain any unearned commission on the policy, and the insurer shall:

(A) Pay to the producing agent ~~of record of the corporation policy~~, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(B) Offer to allow the producing agent ~~of record of the corporation policy~~ to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the greater of the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with sub-sub-sub-subparagraph (A).

c. Effective upon this act becoming a law, the corporation shall cease to accept applications for or issue new policies covering commercial nonresidential risks. ~~For purposes of determining comparable coverage under sub-subparagraphs a. and~~


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~~b., the comparison shall be based on those forms and coverages that are reasonably comparable. The corporation may rely on a determination of comparable coverage and premium made by the producing agent who submits the application to the corporation, made in the agent's capacity as the corporation's agent. A comparison may be made solely of the premium with respect to the main building or structure only on the following basis: the same coverage A or other building limits; the same percentage hurricane deductible that applies on an annual basis or that applies to each hurricane for commercial residential property; the same percentage of ordinance and law coverage, if the same limit is offered by both the corporation and the authorized insurer; the same mitigation credits, to the extent the same types of credits are offered both by the corporation and the authorized insurer; the same method for loss payment, such as replacement cost or actual cash value, if the same method is offered both by the corporation and the authorized insurer in accordance with underwriting rules; and any other form or coverage that is reasonably comparable as determined by the board. If an application is submitted to the corporation for wind-only coverage in the high-risk account, the premium for the corporation's wind-only policy plus the premium for the ex-wind policy that is offered by an authorized insurer to the applicant shall be compared to the premium for multiperil coverage offered by an authorized insurer, subject to the standards for comparison specified in this subparagraph. If the corporation or the applicant requests from the authorized insurer a breakdown of the premium of the offer by types of coverage so that a comparison may be made by the corporation or its agent and the~~

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~~authorized insurer refuses or is unable to provide such information, the corporation may treat the offer as not being an offer of coverage from an authorized insurer at the insurer's approved rate.~~

5.~~6.~~ Must include rules for classifications of risks and rates ~~therefor~~.

6.~~7.~~ Must provide that if premium and investment income for an account attributable to a particular calendar year are in excess of projected losses and expenses for the account attributable to that year, such excess shall be held in surplus in the account. Such surplus must ~~shall~~ be available to defray deficits in that account as to future years and ~~shall be~~ used for that purpose before ~~prior to~~ assessing assessable insurers and assessable insureds as to any calendar year.

7.~~8.~~ Must provide objective criteria and procedures to be uniformly applied to ~~for~~ all applicants in determining whether an individual risk is so hazardous as to be uninsurable. In making this determination and in establishing the criteria and procedures, the following must ~~shall~~ be considered:

a. Whether the likelihood of a loss for the individual risk is substantially higher than for other risks of the same class; and

b. Whether the uncertainty associated with the individual risk is such that an appropriate premium cannot be determined.

The acceptance or rejection of a risk by the corporation shall be construed as the private placement of insurance, and the provisions of chapter 120 do ~~shall~~ not apply.

8.~~9.~~ ~~Must provide that the corporation~~ Shall make its best

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efforts to procure catastrophe reinsurance at reasonable rates, to cover its projected 100-year probable maximum loss as determined by the board of governors.

9.~~10.~~ Must issue ~~The~~ policies that ~~issued by the corporation must~~ provide that, if the corporation or the market assistance plan obtains an offer from an authorized insurer to cover the risk at its approved rates or from a surplus lines insurer, the risk is no longer eligible for renewal through the corporation, except as otherwise provided in this subsection.

10.~~11.~~ Must ~~Corporation Policies and applications must~~ include a notice in the corporation policies and applications that the corporation policy could, under this section, be replaced with a policy issued by an ~~authorized~~ insurer which ~~that~~ does not provide coverage identical to the coverage provided by the corporation. The notice must ~~shall~~ also specify that acceptance of corporation coverage creates a conclusive presumption that the applicant or policyholder is aware of this potential.

11.~~12.~~ May establish, subject to approval by the office, different eligibility requirements and operational procedures for any line or type of coverage for any specified county or area if the board determines that such changes ~~to the eligibility requirements and operational procedures~~ are justified due to the voluntary market being sufficiently stable and competitive in such area or for such line or type of coverage and that consumers who, in good faith, are unable to obtain insurance through the voluntary market through ordinary methods ~~would~~ continue to have access to coverage from the corporation. If ~~When~~ coverage is sought in connection with a

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real property transfer, the ~~such~~ requirements and procedures may ~~shall~~ not provide ~~for~~ an effective date of coverage later than the date of the closing of the transfer as established by the transferor, the transferee, and, if applicable, the lender.

12.~~13.~~ Must provide that, with respect to the high-risk account, any assessable insurer with a surplus as to policyholders of $25 million or less writing 25 percent or more of its total countrywide property insurance premiums in this state may petition the office, within the first 90 days of each calendar year, to qualify as a limited apportionment company. A regular assessment levied by the corporation on a limited apportionment company for a deficit incurred by the corporation for the high-risk account ~~in 2006 or thereafter~~ may be paid to the corporation on a monthly basis as the assessments are collected by the limited apportionment company from its insureds pursuant to s. 627.3512, but the regular assessment must be paid in full within 12 months after being levied by the corporation. A limited apportionment company shall collect from its policyholders any emergency assessment imposed under sub-subparagraph (b)3.d. ~~The plan shall provide that,~~ If the office determines that any regular assessment will result in an impairment of the surplus of a limited apportionment company, the office may direct that all or part of such assessment be deferred as provided in subparagraph (q)4. However, ~~there shall be no limitation or deferment of~~ an emergency assessment to be collected from policyholders under sub-subparagraph (b)3.d. may not be limited or deferred.

13.~~14.~~ Effective January 1, 2012, must ~~provide that the corporation~~ appoint as its licensed agents only those agents who

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also hold an appointment as defined in s. 626.015(3) with an insurer who ~~at the time of the agent's initial appointment by the corporation~~ is authorized to write and is actually writing personal lines residential property coverage, commercial residential property coverage, or commercial nonresidential property coverage within the state.

14.~~15.~~ Must provide~~, by July 1, 2007,~~ a premium payment plan option to its policyholders which, ~~allows~~ at a minimum, allows for quarterly and semiannual payment of premiums. A monthly payment plan may~~, but is not required to,~~ be offered.

15.~~16.~~ Must limit coverage on mobile homes or manufactured homes built before ~~prior to~~ 1994 to actual cash value of the dwelling rather than replacement costs of the dwelling.

16.~~17.~~ May provide such limits of coverage as the board determines, consistent with the requirements of this subsection.

17.~~18.~~ May require commercial property to meet specified hurricane mitigation construction features as a condition of eligibility for coverage.

18. As of January 1, 2012, must require that the agent obtain from an applicant for coverage from the corporation an acknowledgement signed by the applicant, which includes, at a minimum, the following statement:

ACKNOWLEDGEMENT OF POTENTIAL SURCHARGE AND ASSESSMENT LIABILITY:

1. AS A POLICYHOLDER OF CITIZENS PROPERTY INSURANCE CORPORATION, I UNDERSTAND THAT IF THE CORPORATION SUSTAINS A DEFICIT AS A RESULT OF

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HURRICANE LOSSES OR FOR ANY OTHER REASON, MY POLICY COULD BE SUBJECT TO SURCHARGES, WHICH WILL BE DUE AND PAYABLE UPON RENEWAL, CANCELLATION, OR TERMINATION OF THE POLICY, AND THAT THE SURCHARGES COULD BE AS HIGH AS 45 PERCENT OF MY PREMIUM, OR A DIFFERENT AMOUNT AS IMPOSED BY THE FLORIDA LEGISLATURE.

2. I ALSO UNDERSTAND THAT I MAY BE SUBJECT TO EMERGENCY ASSESSMENTS TO THE SAME EXTENT AS POLICYHOLDERS OF OTHER INSURANCE COMPANIES, OR A DIFFERENT AMOUNT AS IMPOSED BY THE FLORIDA LEGISLATURE.

3. I ALSO UNDERSTAND THAT CITIZENS PROPERTY INSURANCE CORPORATION IS NOT SUPPORTED BY THE FULL FAITH AND CREDIT OF THE STATE OF FLORIDA.

a. The corporation shall maintain, in electronic format or otherwise, a copy of the applicant's signed acknowledgement and provide a copy of the statement to the policyholder as part of the first renewal after the effective date of this sub-subparagraph.

b. The signed acknowledgement form creates a conclusive presumption that the policyholder understood and accepted his or her potential surcharge and assessment liability as a policyholder of the corporation.

19. Upon notice and determination by the Department of Financial Services that an agent appointed by the corporation has violated s. 626.9541(1)(h), immediately terminate the agent's appointment to represent the corporation.

20. Must provide that new or renewal policies issued by the

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corporation on or after February 1, 2012, do not include coverage for attached or detached screen enclosures. The corporation shall exclude such coverage using a notice of coverage change, which may be included with the policy renewal, and not by issuance of a notice of nonrenewal of the excluded coverage upon renewal of the current policy.

21. Must provide that new or renewal personal residential policies issued by the corporation on or after February 1, 2013, do not provide coverage for detached structures on the residence premises which are separated from the dwelling by clear space. Structures connected to the dwelling by only a fence, utility line, or similar connection are considered to be detached structures.

22. Must provide that new or renewal personal residential policies issued by the corporation on or after February 1, 2013, do not provide coverage for watercraft, trailers, jewelry, furs, firearms, silverware, business property on premises, business property away from premises, or grave markers.

23. Must offer sinkhole coverage. However, effective February 1, 2012, coverage is not included for losses to appurtenant structures, driveways, sidewalks, decks, or patios which are directly or indirectly caused by sinkhole activity. The corporation shall exclude such coverage using a notice of coverage change, which may be included with the policy renewal, and not by issuance of a notice of nonrenewal of the excluded coverage upon renewal of the current policy.

24. As a condition for making payment for damage caused by the peril of sinkhole, regardless of whether such payment is made pursuant to the contract, mediation, neutral evaluation,

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appraisal, arbitration, settlement, or litigation, the payment must be dedicated entirely to the costs of repairing the structure or remediation of the land. Unless this condition is met, the corporation is prohibited from making payment.

(d)1. All prospective employees for senior management positions, as defined by the plan of operation, are subject to background checks as a prerequisite for employment. The office shall conduct the background checks ~~on such prospective employees~~ pursuant to ss. 624.34, 624.404(3), and 628.261.

2. On or before July 1 of each year, employees of the corporation must ~~are required to~~ sign and submit a statement attesting that they do not have a conflict of interest, as defined in part III of chapter 112. As a condition of employment, all prospective employees must ~~are required to~~ sign and submit to the corporation a conflict-of-interest statement.

3. Senior managers and members of the board of governors are subject to ~~the provisions of~~ part III of chapter 112, including, but not limited to, the code of ethics and public disclosure and reporting of financial interests, pursuant to s. 112.3145.

a. Senior managers and board members are also required to file such disclosures with the Commission on Ethics and the Office of Insurance Regulation. The executive director of the corporation or his or her designee shall notify each existing and newly appointed ~~and existing appointed~~ member of the board of governors and senior managers of their duty to comply with the reporting requirements of part III of chapter 112. At least quarterly, the executive director or his or her designee shall submit to the Commission on Ethics a list of names of the senior

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managers and members of the board of governors who are subject to the public disclosure requirements under s. 112.3145.

b. Notwithstanding s. 112.3143(2), a board member may not vote on any measure that would inure to his or her special private gain or loss; that he or she knows would inure to the special private gain or loss of any principal by whom he or she is retained or to the parent organization or subsidiary of a corporate principal by which he or she is retained, other than an agency as defined in s. 112.312; or that he or she knows would inure to the special private gain or loss of a relative or business associate of the public officer. Before the vote is taken, such member must publicly state to the assembly the nature of his or her interest in the matter from which he or she is abstaining and, within 15 days after the vote occurs, disclose the nature of his or her interest as a public record in a memorandum filed with the person responsible for recording the minutes of the meeting, who shall incorporate the memorandum in the minutes.

4. Notwithstanding s. 112.3148 or s. 112.3149, or any other provision of law, an employee or board member may not knowingly accept, directly or indirectly, any gift or expenditure from a person or entity, or an employee or representative of such person or entity, which ~~that~~ has a contractual relationship with the corporation or who is under consideration for a contract. An employee or board member who fails to comply with subparagraph 3. or this subparagraph is subject to penalties provided under ss. 112.317 and 112.3173.

5. Any senior manager of the corporation who is employed on or after January 1, 2007, regardless of the date of hire, who

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subsequently retires or terminates employment is prohibited from representing another person or entity before the corporation for 2 years after retirement or termination of employment from the corporation.

6. Any senior manager of the corporation who is employed on or after January 1, 2007, regardless of the date of hire, who subsequently retires or terminates employment is prohibited from having any employment or contractual relationship for 2 years with an insurer that has entered into a take-out bonus agreement with the corporation.

(n)~~1.~~ It is the intent of the Legislature that the rates for coverage provided by the corporation be actuarially determined and not be competitive with rates charged in the admitted voluntary market such that the corporation functions as a residual market mechanism that provides insurance only if such insurance cannot be procured in the voluntary market. To achieve this goal, for any rate filing made by the corporation on or after July 1, 2011: ~~Rates for coverage provided by the corporation shall be actuarially sound and subject to the requirements of s. 627.062, except as otherwise provided in this paragraph. The corporation shall file its recommended rates with the office at least annually. The corporation shall provide any additional information regarding the rates which the office requires. The office shall consider the recommendations of the board and issue a final order establishing the rates for the corporation within 45 days after the recommended rates are filed. The corporation may not pursue an administrative challenge or judicial review of the final order of the office.~~

1. The corporation shall file its recommended rates with

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the office at least annually. The office shall consider the recommended rates and issue a final order establishing the rates within 45 days after the recommended rates are filed. The corporation may not pursue an administrative challenge or judicial review of the office's final order.

2. In developing its rates, the corporation shall use an appropriate industry expense equalization factor to ensure that its rates include standard industry ratemaking expense provisions. The industry expense equalization factor must include a catastrophe risk load, a provision for taxes, a market provision for reinsurance costs, and an industry expense provision for general expenses, acquisition expenses, and commissions.

3. The corporation shall implement a rate increase each year for each residential line of business it writes, which may not exceed 20 percent by territory and 25 percent for any single policy, excluding coverage changes and surcharges. This subparagraph expires January 1, 2015, and does not apply to rates for sinkhole coverage or costs for the purchase of private reinsurance, if any.

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

~~3. After the public hurricane loss-projection model under s. 627.06281 has been found to be accurate and reliable by the Florida Commission on Hurricane Loss Projection Methodology, that model shall serve as the minimum benchmark for determining the windstorm portion of the corporation's rates. This~~


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~~subparagraph does not require or allow the corporation to adopt rates lower than the rates otherwise required or allowed by this paragraph.~~

~~4. The rate filings for the corporation which were approved by the office and which took effect January 1, 2007, are rescinded, except for those rates that were lowered. As soon as possible, the corporation shall begin using the lower rates that were in effect on December 31, 2006, and shall provide refunds to policyholders who have paid higher rates as a result of that rate filing. The rates in effect on December 31, 2006, shall remain in effect for the 2007 and 2008 calendar years except for any rate change that results in a lower rate. The next rate change that may increase rates shall take effect pursuant to a new rate filing recommended by the corporation and established by the office, subject to the requirements of this paragraph.~~

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

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

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

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6. This paragraph does not require or allow the corporation to reduce rates.

~~8. The corporation's implementation of rates as prescribed in subparagraph 6. shall cease for any line of business written by the corporation upon the corporation's implementation of actuarially sound rates. Thereafter, the corporation shall annually make a recommended actuarially sound rate filing for each commercial and personal line of business the corporation writes.~~

(o) If coverage in an account is deactivated pursuant to paragraph (p), coverage through the corporation shall be reactivated by order of the office only under one of the following circumstances:

1. If the market assistance plan receives a minimum of 100 applications for coverage within a 3-month period, or 200 applications for coverage within a 1-year period or less for residential coverage, unless the market assistance plan provides a quotation from admitted carriers at their filed rates for at least 90 percent of such applicants. A ~~Any~~ market assistance plan application that is rejected because an individual risk is so hazardous as to be uninsurable using the criteria specified in subparagraph (c)7. may ~~(c)8. shall~~ not be included in the minimum percentage calculation ~~provided herein~~. If ~~In the event that~~ there is a legal or administrative challenge to a determination by the office that the conditions of this subparagraph have been met for eligibility for coverage by ~~in~~ the corporation, an ~~any~~ eligible risk may obtain coverage during the pendency of such challenge.

2. In response to a state of emergency declared by the

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Governor under s. 252.36, the office may activate coverage by order during ~~for the period of~~ the emergency upon a finding by the office that the emergency significantly affects the availability of residential property insurance.

(q)1. The corporation shall certify to the office its needs for annual assessments as to a particular calendar year, and for any interim assessments that it deems to be necessary to sustain operations as to a particular year pending the receipt of annual assessments. Upon verification, the office shall approve such certification, and the corporation shall levy such annual or interim assessments. Such assessments must ~~shall~~ be prorated as provided in paragraph (b). The corporation shall take all reasonable and prudent steps necessary to collect the amount of assessment due from each assessable insurer, including, if prudent, filing suit to collect such assessment. If the corporation is unable to collect an assessment from any assessable insurer, the uncollected assessments shall be levied as an additional assessment against the assessable insurers and any assessable insurer required to pay an additional assessment ~~as a result of such failure to pay~~ shall have a cause of action against such nonpaying assessable insurer. Assessments shall be included as an appropriate factor in the making of rates. The failure of a surplus lines agent to collect and remit any regular or emergency assessment levied by the corporation is ~~considered to be~~ a violation of s. 626.936 and subjects the surplus lines agent to the penalties provided in that section.

2. The governing body of any unit of local government, ~~any~~ residents of which are insured by the corporation, may issue bonds as defined in s. 125.013 or s. 166.101 ~~from time to time~~

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to fund an assistance program, in conjunction with the corporation, for the purpose of defraying deficits of the corporation. In order to avoid needless and indiscriminate proliferation, duplication, and fragmentation of such assistance programs, any unit of local government, ~~any~~ residents of which are insured by the corporation, may provide for the payment of losses, regardless of whether or not the losses occurred within or outside of the territorial jurisdiction of the local government. Revenue bonds under this subparagraph may not be issued until validated pursuant to chapter 75, unless a state of emergency is declared by executive order or proclamation of the Governor pursuant to s. 252.36 making such findings as are necessary to determine that it is in the best interests of, and necessary for, the protection of the public health, safety, and general welfare of residents of this state and declaring it an essential public purpose to permit certain municipalities or counties to issue such bonds <u>to</u> ~~as will~~ permit relief to claimants and policyholders of the corporation. Any such unit of local government may enter into such contracts with the corporation and with any other entity created pursuant to this subsection as are necessary to carry out this paragraph. Any bonds issued under this subparagraph <u>are</u> ~~shall be~~ payable from and secured by moneys received by the corporation from emergency assessments under sub-subparagraph (b)3.d., and assigned and pledged to or on behalf of the unit of local government for the benefit of the holders of such bonds. The funds, credit, property, and taxing power of the state or of the unit of local government <u>may</u> ~~shall~~ not be pledged for the payment of such bonds.


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3.~~a.~~ The corporation shall adopt one or more programs subject to approval by the office for the reduction of both new and renewal writings in the corporation. ~~Beginning January 1, 2008,~~

a. Any program the corporation adopts for the payment of bonuses to an insurer for each risk the insurer removes from the corporation must ~~shall~~ comply with s. 627.3511(2) and may not exceed the amount referenced in s. 627.3511(2) for each risk removed. The corporation may consider any prudent and not unfairly discriminatory approach to reducing corporation writings, and may adopt a credit against assessment liability or other liability that provides an incentive for insurers to take risks out of the corporation and to keep risks out of the corporation by maintaining or increasing voluntary writings in counties or areas in which corporation risks are highly concentrated and a program to provide a formula under which an insurer voluntarily taking risks out of the corporation by maintaining or increasing voluntary writings will be relieved wholly or partially from assessments under sub-subparagraphs (b)3.a. and b. However, any "take-out bonus" or payment to an insurer must be conditioned on the property being insured for at least 5 years by the insurer, unless canceled or nonrenewed by the policyholder. If the policy is canceled or nonrenewed by the policyholder before the end of the 5-year period, the amount of the take-out bonus must be prorated for the time period the policy was insured. If ~~When~~ the corporation enters into a contractual agreement for a take-out plan, the producing agent of record of the corporation policy is entitled to retain any unearned commission on such policy, and the insurer shall

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either:

(I) Pay to the producing agent of record of the policy, for the first year, an amount that ~~which~~ is the greater of the insurer's usual and customary commission for the type of policy written or a policy fee equal to the usual and customary commission of the corporation; or

(II) Offer to allow the producing agent of record of the policy to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the insurer's usual and customary commission for the type of policy written. If the producing agent is unwilling or unable to accept appointment by the new insurer, the new insurer shall pay the agent in accordance with sub-sub-subparagraph (I).

b. Any credit or exemption from regular assessments adopted under this subparagraph shall last no longer than the 3 years following the cancellation or expiration of the policy by the corporation. With the approval of the office, the board may extend such credits for an additional year if the insurer guarantees an additional year of renewability for all policies removed from the corporation, or for 2 additional years if the insurer guarantees 2 additional years of renewability for all policies so removed.

c. ~~There shall be~~ No credit, limitation, exemption, or deferment from emergency assessments may ~~to~~ be collected from policyholders pursuant to sub-subparagraph (b)3.d.

4. The plan must ~~shall~~ provide for the deferment, in whole or in part, of the assessment of an assessable insurer, other than an emergency assessment collected from policyholders pursuant to sub-subparagraph (b)3.d., if the office finds that

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payment of the assessment would endanger or impair the solvency of the insurer. If ~~In the event~~ an assessment against an assessable insurer is deferred in whole or in part, the amount ~~by which such assessment is~~ deferred may be assessed against the other assessable insurers in a manner consistent with the basis for assessments set forth in paragraph (b).

5. ~~Effective July 1, 2007,~~ In order to evaluate the costs and benefits of approved take-out plans, if the corporation pays a bonus or other payment to an insurer for an approved take-out plan, it shall maintain a record of the address or such other identifying information on the property or risk removed in order to track if and when the property or risk is later insured by the corporation.

6. Any policy taken out, assumed, or removed from the corporation is, as of the effective date of the take-out, assumption, or removal, direct insurance issued by the insurer and not by the corporation, even if the corporation continues to service the policies. This subparagraph applies to policies of the corporation and not policies taken out, assumed, or removed from any other entity.

d. Notwithstanding any other provision of law, for purposes of a depopulation, take-out, or keep-out program adopted by the corporation, including an initial or renewal offer of coverage made to a policyholder removed from the corporation pursuant to such program, an eligible surplus lines insurer may participate in the program in the same manner and on the same terms as an authorized insurer, except as provided under this subparagraph. To qualify for participation, the surplus lines insurer must first obtain approval from the office for its depopulation,

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take-out, or keep-out plan and then comply with all of the corporation's requirements for such plan applicable to admitted insurers and with all statutory provisions applicable to the removal of policies from the corporation. In considering a surplus lines insurer's request for approval for its plan, the office must determine that the surplus lines insurer meets the following requirements:

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

(II) Maintains an A.M. Best Financial Strength Rating of "A-" or better;

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

(IV) Provides prominent notice to the policyholder before the assumption of the policy that surplus lines policies are not provided coverage by the Florida Insurance Guaranty Association, and an outline of any substantial differences in coverage between the existing policy and the policy being offered to the insured; and

(V) Provides similar policy coverage.

This sub-subparagraph does not subject any surplus lines insurer to requirements in addition to part VIII of chapter 626. Surplus lines brokers making an offer of coverage under this sub-subparagraph are not required to comply with s. 626.916(1)(a), (b), (c), and (e).

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(s)1. There is ~~shall be~~ no liability on the part of, and no cause of action ~~of any nature~~ shall arise against, any assessable insurer or its agents or employees, the corporation or its agents or employees, members of the board of governors or their respective designees at a board meeting, corporation committee members, or the office or its representatives, for any action taken by them in the performance of their duties or responsibilities under this subsection.

a. As part of the immunity, the corporation, as a governmental entity serving a public purpose, is not liable for any claim for bad faith whether or not brought pursuant to s. 624.155, and this subsection or any other provision of law does not create liability or a cause of action for bad faith or a claim for extracontractual damages.

b. Such immunity does not apply to:

(I)~~a.~~ Any of the foregoing persons or entities for any willful tort;

(II)~~b.~~ The corporation or its producing agents for breach of any contract or agreement pertaining to insurance coverage;

(III)~~c.~~ The corporation with respect to issuance or payment of debt;

(IV)~~d.~~ An ~~Any~~ assessable insurer with respect to any action to enforce an assessable insurer's obligations to the corporation under this subsection; or

(V)~~c.~~ The corporation in any pending or future action for breach of contract or for benefits under a policy issued by the corporation.~~;~~ In any such action, the corporation is not ~~shall be~~ liable to the policyholders and beneficiaries for attorney's fees under s. 627.428.

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2. The corporation shall manage its claim employees, independent adjusters, and others who handle claims to ensure they carry out the corporation's duty to its policyholders to handle claims carefully, timely, diligently, and in good faith, balanced against the corporation's duty to the state to manage its assets responsibly in order to minimize its assessment potential.

(w) Notwithstanding any other provision of law:

1. The pledge or sale of, the lien upon, and the security interest in any rights, revenues, or other assets of the corporation created or purported to be created pursuant to any financing documents to secure any bonds or other indebtedness of the corporation shall be and remain valid and enforceable, notwithstanding the commencement of and during the continuation of, and after, any rehabilitation, insolvency, liquidation, bankruptcy, receivership, conservatorship, reorganization, or similar proceeding against the corporation under the laws of this state.

2. ~~No~~ Such proceeding does not ~~shall~~ relieve the corporation of its obligation, or otherwise affect its ability to perform its obligation, to continue to collect, or levy and collect, assessments, market equalization or other surcharges ~~under subparagraph (c)10.~~, or any other rights, revenues, or other assets of the corporation pledged pursuant to any financing documents.

3. Each such pledge or sale of, lien upon, and security interest in, including the priority of such pledge, lien, or security interest, any such assessments, market equalization or other surcharges, or other rights, revenues, or other assets

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which are collected, or levied and collected, after the commencement of and during the pendency of, or after, any such proceeding continues ~~shall continue~~ unaffected by such proceeding. As used in this subsection, the term "financing documents" means any agreement or agreements, instrument or instruments, or other document or documents now existing or hereafter created evidencing any bonds or other indebtedness of the corporation or pursuant to which any such bonds or other indebtedness has been or may be issued and pursuant to which any rights, revenues, or other assets of the corporation are pledged or sold to secure the repayment of such bonds or indebtedness, together with the payment of interest on such bonds or such indebtedness, or the payment of any other obligation or financial product, as defined in the plan of operation of the corporation related to such bonds or indebtedness.

4. Any such pledge or sale of assessments, revenues, contract rights, or other rights or assets of the corporation constitutes ~~shall constitute~~ a lien and security interest, or sale, as the case may be, that is immediately effective and attaches to such assessments, revenues, or contract rights or other rights or assets, whether or not imposed or collected at the time the pledge or sale is made. ~~Any~~ Such pledge or sale is effective, valid, binding, and enforceable against the corporation or other entity making such pledge or sale, and valid and binding against and superior to any competing claims or obligations owed to any other person or entity, including policyholders in this state, asserting rights in any such assessments, revenues, or contract rights or other rights or assets to the extent set forth in and in accordance with the

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terms of the pledge or sale contained in the applicable financing documents, whether or not any such person or entity has notice of such pledge or sale and without the need for any physical delivery, recordation, filing, or other action.

5. If ~~As long as~~ the corporation has any bonds outstanding, the corporation may not file a voluntary petition under chapter 9 of the federal Bankruptcy Code or such corresponding chapter or sections as may be in effect, ~~from time to time,~~ and a public officer or any organization, entity, or other person may not authorize the corporation to be or become a debtor under chapter 9 of the federal Bankruptcy Code or such corresponding chapter or sections as may be in effect~~, from time to time,~~ during any such period.

6. If ordered by a court ~~of competent jurisdiction~~, the corporation may assume policies or otherwise provide coverage for policyholders of an insurer placed in liquidation under chapter 631, under such forms, rates, terms, and conditions as the corporation deems appropriate, subject to approval by the office.

(x)1. The following records of the corporation are confidential and exempt from ~~the provisions of~~ s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

a. Underwriting files, except that a policyholder or an applicant shall have access to his or her own underwriting files. Confidential and exempt underwriting file records may also be released to other governmental agencies upon written request and demonstration of need; such records held by the receiving agency remain confidential and exempt as provided herein.

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b. Claims files, until termination of all litigation and settlement of all claims arising out of the same incident, although portions of the claims files may remain exempt, as otherwise provided by law. Confidential and exempt claims file records may be released to other governmental agencies upon written request and demonstration of need; such records held by the receiving agency remain confidential and exempt as provided herein.

c. Records obtained or generated by an internal auditor pursuant to a routine audit, until the audit is completed, or if the audit is conducted as part of an investigation, until the investigation is closed or ceases to be active. An investigation is considered "active" while the investigation is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings.

d. Matters reasonably encompassed in privileged attorney-client communications.

e. Proprietary information licensed to the corporation under contract and the contract provides for the confidentiality of such proprietary information.

f. All information relating to the medical condition or medical status of a corporation employee which is not relevant to the employee's capacity to perform his or her duties, except as otherwise provided in this paragraph. Information that is exempt shall include, but is not limited to, information relating to workers' compensation, insurance benefits, and retirement or disability benefits.

g. Upon an employee's entrance into the employee assistance

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program, a program to assist any employee who has a behavioral or medical disorder, substance abuse problem, or emotional difficulty which affects the employee's job performance, all records relative to that participation shall be confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, except as otherwise provided in s. 112.0455(11).

h. Information relating to negotiations for financing, reinsurance, depopulation, or contractual services, until the conclusion of the negotiations.

i. Minutes of closed meetings regarding underwriting files, and minutes of closed meetings regarding an open claims file until termination of all litigation and settlement of all claims with regard to that claim, except that information otherwise confidential or exempt by law shall be redacted.

2. If an ~~authorized~~ insurer is considering underwriting a risk insured by the corporation or has removed a risk from the corporation, relevant underwriting files and confidential claims files may be released to the insurer if ~~provided~~ the insurer agrees in writing, notarized and under oath, to maintain the confidentiality of such files. If a file is transferred to an insurer, that file is no longer a public record because it is not held by an agency subject to the provisions of the public records law. Underwriting files and confidential claims files may also be released to staff and the board of governors of the market assistance plan established pursuant to s. 627.3515, who must retain the confidentiality of such files, except such files may be released to authorized insurers that are considering assuming the risks to which the files apply if~~, provided~~ the

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insurer agrees in writing, notarized and under oath, to maintain the confidentiality of such files. Finally, the corporation or the board or staff of the market assistance plan may make the following information obtained from underwriting files and confidential claims files available to licensed general lines insurance agents: name, address, and telephone number of the residential property owner or insured; location of the risk; rating information; loss history; and policy type. The receiving licensed general lines insurance agent must retain the confidentiality of the information received.

3. A policyholder who has filed suit against the corporation has the right to discover the contents of his or her own claims file to the same extent that discovery of such contents would be available from a private insurer in litigation as provided by the Florida Rules of Civil Procedure, the Florida Evidence Code, and other applicable law. Pursuant to subpoena, a third party has the right to discover the contents of an insured's or applicant's underwriting or claims file to the same extent that discovery of such contents would be available from a private insurer by subpoena as provided by the Florida Rules of Civil Procedure, the Florida Evidence Code, and other applicable law, and subject to any confidentiality protections requested by the corporation and agreed to by the seeking party or ordered by the court. The corporation may release confidential underwriting and claims file contents and information as it deems necessary and appropriate to underwrite or service insurance policies and claims, subject to any confidentiality protections deemed necessary and appropriate by the corporation.

4. Portions of meetings of the corporation are exempt from

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the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution wherein confidential underwriting files or confidential open claims files are discussed. All portions of corporation meetings which are closed to the public shall be recorded by a court reporter. The court reporter shall record the times of commencement and termination of the meeting, all discussion and proceedings, the names of all persons present at any time, and the names of all persons speaking. No portion of any closed meeting shall be off the record. Subject to the provisions hereof and s. 119.07(1)(d)-(f), the court reporter's notes of any closed meeting shall be retained by the corporation for a minimum of 5 years. A copy of the transcript, less any exempt matters, of any closed meeting wherein claims are discussed shall become public as to individual claims after settlement of the claim.

(y) It is the intent of the Legislature that the amendments to this subsection enacted in 2002 should, over time, reduce the probable maximum windstorm losses in the residual markets and ~~should~~ reduce the potential assessments to be levied on property insurers and policyholders statewide. ~~In furtherance of this intent:~~

~~1. The board shall, on or before February 1 of each year, provide a report to the President of the Senate and the Speaker of the House of Representatives showing the reduction or increase in the 100-year probable maximum loss attributable to wind-only coverages and the quota share program under this subsection combined, as compared to the benchmark 100-year probable maximum loss of the Florida Windstorm Underwriting Association. For purposes of this paragraph, the benchmark 100-~~


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~~year probable maximum loss of the Florida Windstorm Underwriting Association shall be the calculation dated February 2001 and based on November 30, 2000, exposures. In order to ensure comparability of data, the board shall use the same methods for calculating its probable maximum loss as were used to calculate the benchmark probable maximum loss.~~

~~2. Beginning December 1, 2010, if the report under subparagraph 1. for any year indicates that the 100-year probable maximum loss attributable to wind-only coverages and the quota share program combined does not reflect a reduction of at least 25 percent from the benchmark, the board shall reduce the boundaries of the high-risk area eligible for wind-only coverages under this subsection in a manner calculated to reduce such probable maximum loss to an amount at least 25 percent below the benchmark.~~

~~3. Beginning February 1, 2015, if the report under subparagraph 1. for any year indicates that the 100-year probable maximum loss attributable to wind-only coverages and the quota share program combined does not reflect a reduction of at least 50 percent from the benchmark, the boundaries of the high-risk area eligible for wind-only coverages under this subsection shall be reduced by the elimination of any area that is not seaward of a line 1,000 feet inland from the Intracoastal Waterway.~~

(aa) As a condition of eligibility for coverage by the corporation, an applicant or insured of a property located in Special Flood Hazard Area, as defined by the National Flood Insurance Program, must maintain in effect a separate flood insurance policy having coverage limits for building and

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contents at least equal to those provided under the corporation's policy, subject to the maximum limits available under the National Flood Insurance Program policy. This requirement does not apply to an insured who is a tenant or a condominium unit owner above the ground floor; a policy issued by the corporation which excludes wind and hail coverage; a risk that is not eligible for flood coverage under the National Flood Insurance Program; or a mobile home that is located more than 2 miles from open water, including the ocean, the gulf, a bay, a river, or the intracoastal waterway. This paragraph applies to new policies issued by the corporation on or after January 1, 2012, and to policies renewed by the corporation on or after January 1, 2013. ~~The corporation shall not require the securing of flood insurance as a condition of coverage if the insured or applicant executes a form approved by the office affirming that flood insurance is not provided by the corporation and that if flood insurance is not secured by the applicant or insured in addition to coverage by the corporation, the risk will not be covered for flood damage. A corporation policyholder electing not to secure flood insurance and executing a form as provided herein making a claim for water damage against the corporation shall have the burden of proving the damage was not caused by flooding. Notwithstanding other provisions of this subsection, the corporation may deny coverage to an applicant or insured who refuses to execute the form described herein.~~

~~(cc) The office may establish a pilot program to offer optional sinkhole coverage in one or more counties or other territories of the corporation for the purpose of implementing s. 627.706, as amended by s. 30, chapter 2007-1, Laws of~~

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~~Florida. Under the pilot program, the corporation is not required to issue a notice of nonrenewal to exclude sinkhole coverage upon the renewal of existing policies, but may exclude such coverage using a notice of coverage change.~~

Section 3. Subsection (4) of section 627.3511, Florida Statutes, is amended to read:

627.3511 Depopulation of Citizens Property Insurance Corporation.—

(4) AGENT BONUS.—If ~~When~~ the corporation enters into a contractual agreement for a take-out plan that provides a bonus to the insurer, the producing agent of record of the corporation policy is entitled to retain any unearned commission on such policy, and the insurer shall ~~either~~:

(a) Pay to the producing agent ~~of record of the association policy~~, for the first year, an amount that is the greater of the insurer's usual and customary commission for the type of policy written or a fee equal to the usual and customary commission of the corporation; or

(b) Offer to allow the producing agent ~~of record of the corporation policy~~ to continue servicing the policy for at least ~~a period of not less than~~ 1 year and offer to pay the agent the greater of the insurer's or the corporation's usual and customary commission for the type of policy written.

If the producing agent is unwilling or unable to accept appointment, the new insurer shall pay the agent in accordance with paragraph (a). The requirement ~~of this subsection~~ that the producing agent of record is entitled to retain the unearned commission on an association policy does not apply to a policy

for which coverage has been provided in the association for 30 days or less ~~or for which a cancellation notice has been issued pursuant to s. 627.351(6)(c)10. during the first 30 days of coverage~~.

Section 5. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the Citizens Property Insurance Corporation; amending s. 627.0655, F.S.; discontinuing policy discounts relating to the Citizens Property Insurance Corporation after a certain date; amending s. 627.351, F.S.; revising legislative intent; deleting obsolete provisions relating to the corporation's plan of operation; providing that certain residential structures are not eligible for coverage by the corporation after a certain date; requiring policies issued by the corporation to include a provision that prohibits policyholders from engaging the services of a public adjuster until after the corporation has tendered an offer; limiting an adjuster's fee for a claim against the corporation; specifying the percentage amount of emergency assessments; revising provisions relating to policyholder surcharges; prohibiting the corporation from levying certain assessments with respect to a

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year's deficit until the corporation has first levied a specified surcharge; requiring the corporation to commission a consultant to prepare a report on outsourcing various functions and submit such report to the Financial Services Commission by a certain date; revising provisions relating to wind coverage; prohibiting the corporation from accepting applications for commercial nonresidential risks; requiring the policyholders to sign a statement acknowledging that they may be assessed surcharges to cover corporate deficits; providing that policies do not include coverage for screen enclosures or any structure detached from the house; providing that the corporation does not cover specified personal property; limiting coverage for damage from sinkholes after a certain date and providing that the corporation must require repair of the property as a condition of any payment; requiring members of the board of governors to abstain from voting on issues on which they have a personal interest; requiring such members to disclose the nature of their interest as a public record; providing that the corporation operates as a residual market mechanism; revising provisions relating to corporation rates; providing that eligible surplus lines insurers may participate in take-out programs under certain conditions; clarifying that the corporation is immune from certain liabilities; revising requirements relating to confidential records released by an insurer; deleting a requirement for an


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annual report to the Legislature on losses attributable to wind-only coverages; requiring owners of properties in Special Flood Hazard Areas to maintain a separate flood insurance policy after a certain date; providing exceptions; amending s. 627.3511, F.S.; conforming a cross-reference; providing an effective date.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment to Amendment (946762) (with title amendment)

Delete lines 184 - 195

and insert:

5. Effective October 1, 2011 ~~January 1, 2009~~, a personal lines residential structure that is located in the "wind-borne debris region," as defined in s. 1609.2, International Building Code (2006), and that has an insured value on the structure of $750,000 or more is ~~not~~ eligible for coverage by the corporation. However, unless the structure has opening protections as required under the Florida Building Code for a

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newly constructed residential structure in that area, the corporation may charge a surcharge that it deems appropriate for such structures, notwithstanding any restrictions on rates provided in this subsection or in s. 627.062. A residential structure shall be deemed to comply with ~~the requirements of~~ this subparagraph if it has shutters or opening protections on all openings and if such opening protections complied with the Florida Building Code at the time they were installed.

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

And the title is amended as follows:

Delete line 1770

and insert:

corporation's plan of operation; directing the corporation to provide coverage to certain excluded residential structures but at rates deemed appropriate by the corporation; providing that

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 Banking and Insurance Committee

BILL:	SB 1714
INTRODUCER:	Senator Hays
SUBJECT:	Citizens Property Insurance Corporation
DATE:	March 27, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

Senate Bill 1714 enacts changes to Citizens Property Insurance Corporation (Citizens), not-for-profit, tax-exempt governmental entity that provides property insurance coverage to those unable to find coverage in the voluntary admitted market. The bill does the following:

Eligibility Requirements

- Applicants for Citizens personal lines residential (homeowners) coverage or commercial lines residential coverage are ineligible to obtain such coverage if the premium for coverage from an authorized insurer is within 25 percent of the Citizens premium. As of January 1, 2015, such applicants are ineligible for Citizens coverage upon receiving an offer of private market coverage at any approved rate.
- As of 2012, all structures with a replacement value of $1 million or more are ineligible for Citizens.
- As of 2014, residential structures in the Personal Lines Account with a replacement value of $750,000 or more are ineligible for coverage.
- As of 2016, residential structures in the Personal Lines Account with a replacement value of $500,000 or more are ineligible for coverage.
- A Citizens applicant or policyholder must maintain a separate flood insurance policy that has coverage limits for the building and contents equal to those provided under the Corporations' policy, subject to the maximum limits available under the National Flood Insurance Program if the property is located in a Special Flood Hazard Area as defined by the National Flood Insurance Program (NFIP).

Citizens Rates

- Citizens must implement a rate increase of up to 20 percent by territory and 25 percent for any single policy each year for each residential line of business it writes. The mandatory rate increase expires January 1, 2015. The limitation on rate increases does not apply to sinkhole coverage or costs incurred through the purchase of private reinsurance.
- Citizens must develop its rates using an industry expense equalization factor.
- Citizens is prohibited from reducing rates.

Citizens Coverage

- Citizens may not offer or renew HO-3 homeowners policies as of December 31, 2012. Instead, Citizens must offer a policy similar to what is available in the private insurance market under an HO-3 (homeowners), HO-4 (renters), or HO-6 (condominium) policy.
- Citizens must cease issuing new commercial nonresidential insurance policies.
- Policies effective on or after January 1, 2012, that include the sinkhole coverage will only cover sinkhole losses to the primary structure.

Citizens Surcharges and Assessments

- Citizens must levy the full amount of the Citizens policyholder surcharge before levying a regular assessment.
- Citizens policyholders must pay emergency assessments that are 1.5 times the emergency assessment levied on insureds in the private insurance market.
- As of January 1, 2012, an agent seeking to place coverage with Citizens must obtain a the applicant's signature on a written disclosure of liability to surcharges and assessments.

Other Provisions

- Clarifies existing law that Citizens is not subject to bad faith liability.
- Prohibits policyholders from engaging the services of a public adjuster with respect to any claim incurred under a policy issues by Citizens.
- Deletes requirements that Citizens reduce the boundaries of the high-risk area.
- Citizens must enact recommendations by an independent third-party consultant on the relative costs and benefits of outsourcing Citizens policy issuance and service functions to private servicing carriers or similar entities.
- Repeals the Citizens quota-share insurance program.
- Provides conflict of interest procedures for Citizens board members.

The bill is effective upon becoming a law.

This bill substantially amends the following sections of the Florida Statutes: 627.351.

II. Present Situation:

Citizens Property Insurance Corporation

Citizens Property Insurance Corporation (Citizens) is a state-created, not-for-profit, tax-exempt entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market.[1] It is a governmental entity and not a private insurance company.[2] Created in 2002 by the Florida Legislature, Citizens combined the state's two insurers of last resort, the Florida Residential Property and Casualty Joint Underwriting Association (RPCJUA) and the Florida Windstorm Underwriting Association (FWUA). The merger allowed Citizens to become exempt from federal income taxes, resulting in millions of dollars in annual savings, as well as additional administrative and economic efficiencies.

Citizens operates under the direction of an 8-member Board of Governors[3] and offers three types of property and casualty insurance in three separate accounts. Each account is a separate statutory account with separate calculations of surplus and deficits.[4] Assets may not be commingled or used to fund losses in another account.[5] In its most recent monthly report,[6] Citizens reported the following data as of February 28, 2011:

- Personal Lines Account (PLA): Statewide account offering multiperil policies covering homeowners, mobile homeowners, dwelling fire, tenants, condominium unit owners, and similar policies.
    - 854,701 Policies in Force
    - $194,695,466,632 Total Exposure
    - $1,330,029,554 In Force Premium
- Commercial Lines Account (CLA): Statewide account offering multiperil policies covering commercial residential-condominium associations, apartment buildings and homeowners associations; and commercial non-residential policies.
    - 8,377 Policies in Force
    - $42,309,533,919 Total Exposure
    - $213,883,613 In Force Premium
- High-Risk Account (HRA): Coastal area account offering personal residential wind-only policies, commercial residential wind-only policies and commercial non-residential wind-only policies issued in limited eligible coastal areas. In addition, in August of 2007, Citizens began offering personal and commercial residential multiperil policies in the HRA.
    - 445,779 Policies in Force
    - $229,169,417,342 Total Exposure
    - $1,141,058,109 In Force Premium
- Total All Accounts Combined:

[1] Admitted market means insurance companies licensed to transact insurance in Florida.
[2] Section 627.351(6)(a)1., F.S. Citizens is also subject to regulation by the Office of Insurance Regulation.
[3] The Governor, the Chief Financial Officer, the President of the Senate and the Speaker of the House of Representatives appoint two members each.
[4] The Personal Lines Account and the Commercial Lines account are combined for credit and Florida Hurricane Catastrophe Fund coverage.
[5] Section 627.351(6)(b)2b., F.S
[6] *See* https://www.citizensfla.com/about/corpfinancials.cfm; last visited March 26, 2011.

- 1,308,857 Policies in Force
- $466,174,417,893 Total Exposure
- $2,684,971,276 In Force Premium

Citizens financial resources include insurance premiums, investment income, operating surplus from prior years, Florida Hurricane Catastrophe Fund (FHCF) reimbursements, its policyholder surcharges, and regular and emergency assessments. With the estimated income from 2011, Citizens will have an accumulated surplus of approximately $5.4 billion. Citizens has approximately $6.3 billion in mandatory layer reinsurance from tha FHCF. Citizens has additional pre-event liquidity of $2.9 billion. Aggregately, for 2011 Citizens has a claims paying capacity of $14.672 billion.

Citizens' probable maximum loss (PML) from a 1-in-100 year event is $22.2 billion. In the event Citizens incurs a deficit (i.e. its obligations to pay claims exceed its capital plus reinsurance recoveries), it may levy regular assessments on most of Florida's property and casualty insurance policyholders in a specific sequence set by statute as follows:[7]

- Require up to a 15 percent of premium surcharge for 12 months on all Citizens' policies, collected upon issuance or renewal. This 15 percent assessment can be levied on each of the three Citizens' accounts with a maximum assessment of 45 percent of premium.
- If the Citizens' surcharge is insufficient to cure the deficit for any individual account, Citizens can require an assessment against insurers (which may be recouped from their policyholders through a rate filing process) of up to 6 percent of premium for most lines of property and casualty insurance, or 6 percent of the deficit, whichever is greater. This assessment may also be levied per account for a maximum total assessment of 18 percent; however, this assessment is not levied against Citizens' policyholders.
- Require any remaining deficit to be funded by multi-year emergency assessments on policyholders on most types of property and casualty insurance, including Citizens' policies, of up to 10 percent of premium for most lines of property and casualty insurance, or 10 percent of the deficit, whichever is greater. This assessment may be levied per account for a total maximum assessment of 30 percent per policy.

Citizens Rates

Until 2010, Citizens rates had been frozen by statute[8] at the level that had been established in 2006. In 2010, the legislature established a "glide path" to impose annual rate increases up to a level that is actuarially sound.[9] Citizens must implement an annual rate increase which does not exceed 10 percent above the previous year for any individual policyholder, adjusted for coverage changes and surcharges. The implementation of this increase ceases when Citizens has achieved actuarially sound rates. In addition to the overall glide path rate increase, Citizens can increase its rates to recover the additional reimbursement premium that it incurs as a result of the annual cash build-up factor added to the price of the mandatory layer of the FHCF coverage, pursuant to s. 215.555(5)(b), F.S.

[7] Section 627.351(6)(b)3.a.,d., and i., F.S.
[8] Section 627.351(6)(n)4., F.S.
[9] Ch. 2009-87; s.10, L.O.F.

Citizens Sinkhole Experience

Insurers, including Citizens, offering property insurance to homeowners in Florida have been required to offer coverage for damages resulting from sinkholes since 1981.[10] Under current law, insurers must make available to policyholders, for an appropriate additional premium, sinkhole coverage for losses on any structure, including personal property contents. Sinkhole coverage includes repairing the home, stabilizing the underlying land, and foundation repairs. Property insurers must also provide coverage for catastrophic ground cover collapse.[11] According to a data call issued by the Office of Insurance Regulation (OIR) in 2010, 66 percent of Florida's sinkhole claims were filed in three counties, Hernando, Pasco and Hillsborough.

The largest writer of sinkhole coverage in Florida is Citizens, and its market share of the sinkhole coverage is even higher in the three counties of greatest activity (Hernando, Pasco and Hillsborough). The rate that Citizens is authorized to charge for sinkhole coverage is far below that which would be necessary to cover the sinkhole losses it incurs, particularly in Hernando, Pasco and Hillsborough. Some examples of Citizens' sinkhole rate deficiency are as follows: In 2009, sinkhole losses[12] from Hernando were almost seven times the premium that was collected to cover those losses. The total premium in Hernando to cover sinkhole losses was $5.9 million, but the losses in Hernando were $40.5 million.

In fact, sinkhole losses from Hernando alone were nearly twice the amount of the entire statewide premium. The total premium collected statewide for the sinkhole endorsement in 2009 was $22.2 million, while in Hernando sinkholes losses were $40.5 million. Pure premium is the term used to describe the amount that all policyholders with the sinkhole endorsement would need to pay to cover the sinkhole losses (with no profit or indirect costs added). The statewide sinkhole pure premium was $295, while the sinkhole premium that Citizens was allowed to collect to cover sinkholes averaged only $73. The pure premium for Hernando sinkhole losses was $5,300, but the average premium was only $775 for this coverage.

The high cost of sinkhole losses is a result the combination of the two primary components of total losses: claims frequency and claims severity. Claims frequency is commonly measured as a percentage: the ratio of the number of claims compared to the number of policyholders in a given period. Citizens' statewide claims frequency more than doubled from two-tenths of a percent in 2005 to almost one-half percent in 2009. In Hernando, Citizens' claims frequency in 2009 was six times what it was in 2005, going from approximately one percent in 2005 to almost seven percent in 2009. This means that for every 100 policyholders purchasing coverage in 2009, seven policyholders filed a claim.

The extraordinary rise in the claims frequency ratio resulted from the fact that the actual number of claims continues to rise, even while the number of policyholders selecting to purchase the coverage is declining. Sinkhole coverage became an optional endorsement in 2007 (although ground cover collapse remains a mandatory coverage), and a significant number of policyholders

[10] Ch. 81-280, L.O.F.
[11] Catastrophic ground cover collapse refers to damage from an abrupt ground collapse for which the property is condemned.
[12] As used here, "losses" refers to indemnity costs for both open and closed claims, plus loss adjustment expenses (LAE). A loss adjustment expense (LAE) is the direct cost associated with investigating, administering, defending, or paying an insurance claim.

began to drop the sinkhole coverage. As a result of this substantial reduction in the number of people choosing to pay for sinkhole coverage, the problems of the increasing number of claims is magnified by the fact that there are fewer policyholders (and therefore less total collected premium) over which to spread the increasing losses. Citizens data shows:

- The percent of Citizens' statewide policies with sinkhole coverage fell from 100 percent in 2006 (when it was mandatory) to 61 percent in 2009.
- In Hernando County, the percent of Citizens' policies with sinkhole coverage fell from 100 percent in 2006 to 37 percent in 2009.
- In Pasco County, the percent of Citizens' policies with sinkhole coverage fell from 100 percent in 2006 to 22 percent 2009.

Notwithstanding the substantial reduction in the number of policyholders choosing sinkhole coverage, there has still been a rise in the number of sinkhole claims being filed. Citizens' data shows:

- Statewide, the number of sinkhole claims more than doubled between 2005 and 2009, rising from 660 in 2005 to 1404 in 2009.
- In Hernando County, the number of sinkhole claims more than quadrupled, rising from 113 in 2005 to 520 in 2009.

The other primary component driving the sinkhole losses is the average claim severity. The average severity is the average amount of cost that Citizens incurred (indemnity plus LAE) for all claims for which a payment was made. Citizens' average annual claim severity between 2005 and 2009 averaged $130,191, with a range from $91,717 (2009) to $155,286 (2007). In 2005, the average claim severity actually exceeded the average coverage limit for the structure.

Bad Faith Claims

Bad faith liability is premised on the concept that an insurer that handles a claim should act in good faith towards its insured and "has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business."[13] Florida recognizes two bad faith causes of actions against insurers: first party bad faith and third party bad faith. Florida first recognized Third-party bad faith at common law in 1938.[14] Third-party bad faith protects an insured from the insurer failing to settle a claim brought by a third party in good faith and exposing the insured to a judgment in excess of policy limits. Florida courts refused to recognize a first-party bad faith tort until it was established by the Legislature in 1982 with the enactment of section 624.155, Florida Statutes, the Civil Remedy statute.

Section 624.155, Florida Statutes permits any person to bring a civil action against an insurer when the insurer commits certain acts or the insured is damaged by statutory violations[15] of the insurer. Specifically, the insurer may bring the claim when the insurer does not attempt to settle a

[13] *Boston Old Colony Ins. Co. v. Gutierrez*, 386 So.2d 783 (Fla. 1980)
[14] *See* *Auto. Mut. Indem. Co. v. Shaw*, 134 Fla. 815, 184 So. 852 (1938).
[15] Violations giving rise to a statutory bad faith claim are s. 626.9541(1)(i), (o), or (x), F.S.; s. 626.9551, F.S.; s. 626.9705, F.S.; s. 626.9706, F.S.; s. 626.9707, F.S.; or s. 627.7283, F.S.

claim in good faith when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward the insured and with due regard to the interests of the insured. A claim may also be brought if the insurer makes claims payments without identifying the coverage under which the payment is made or attempts to influence settlements under one portion of the insurance policy by refusing to promptly resolve a claim it should settle under another portion of the policy.

The insurer is not liable for bad faith liability until the Plaintiff obtains an adjudication in its favor at trial or on appeal, at which point insurer liability for bad faith, costs and reasonable attorney's fees attaches. The insured must prove that the insured committed bad faith in order to obtain recovery. In order to bring an action under s. 624.155, F.S., the Plaintiff must provide the authorized insurer and the Department of Financial Services 60-days written notice of the violation. The notice must detail the statutory provisions the insurer is alleged to have violated, the facts and circumstances giving rise to the violation, reference to insurance policy language relevant to the violation. No action for bad faith may be brought if the insurer pays the requested damages or corrects the circumstances giving rise to the violation within 60 days.

Citizens Property Insurance Corporation has generally been considered to be immune from statutory bad faith liability based upon its sovereign immunity from suit in s. 627.351(6)(s)1., F.S. The courts have noted that the statute creates exemptions from Citizens' grant of immunity, but that an action for bad faith is not one of the exceptions.[16] However, a recent decision of the First District Court of Appeals refused to reverse a trial court determination that Citizens is subject to bad faith liability based on the exceptions to Citizens' immunity for willful torts and a breach of the insurance contract.[17]

III. Effect of Proposed Changes:

Section 1. Amends s. 627.631(6), F.S., governing Citizens Property Insurance Corporation.

Revision of Legislative Intent Language

The bill revises Citizens intent language primarily by deleting language that the Legislature intends for Citizens to provide affordable coverage.

Citizens Eligibility – Prohibitions on Higher Value Structures

Citizens will cease writing coverage for:

- Structures with a dwelling replacement cost of $1 million or more or a single condominium unit with a combined dwelling and contents replacement cost of $1 million or more on January 1, 2012
- Structures in the personal lines account with a dwelling replacement cost of $750,000 or more or a single condominium unit with a combined dwelling and contents replacement cost of $750,000 or more on January 1, 2014

[16] *Citizens Prop. Ins. Co. v. Garfinkel*, 25 So.3d 62 (Fla. 5th DCA 2009).
[17] *Citizens Prop. Ins. Co. v. San Perdido Ass'n, Inc.*, 46 So.3d 1051 (Fla 1st DCA 2010).

- Structures in the personal lines account with a dwelling replacement cost of $500,000 or more or a single condominium unit with a combined dwelling and contents replacement cost of $500,000 or more on January 1, 2016

Essentially, the bill creates a two-tiered prohibition on Citizens coverage. As of 2012, all structures with a replacement value of $1 million or more will be ineligible for Citizens, while residential structures in the Personal Lines Account will have more stringent prohibitions beginning in 2014. A risk that becomes ineligible for Citizens coverage but is insured by a Citizens policy will continue to be insured through the end of the policy term. For instance, if a structure is valued at $1 million and has a Citizens policy that terminates June 1, 2012, will continue to be insured by Citizens for the full term of the policy, but will not be renewed.

Citizens Eligibility – Offers of Coverage from Authorized Private Market Insurers

The bill revises the eligibility criteria for obtaining a Citizens policy for personal lines residential risks and commercial lines residential risks. For personal lines residential policies (homeowners), if the new policy will be effective before January 1, 2015, the applicant is ineligible to obtain such coverage from Citizens if the premium for coverage from an authorized insurer is within 25 percent of the Citizens premium. For example, if a consumer applies for coverage with Citizens and the Citizens premium is $1,000, the policyholder is eligible for Citizens coverage only if the applicant cannot obtain private market insurance for at a premium of $1,250 or less. For new policies effective on January 1, 2015 and thereafter, a risk is ineligible for Citizens coverage if it has an offer of coverage that includes wind coverage from a private market insurer at the insurer's approved rate.

For commercial lines residential policies, if the new policy will be effective before January 1, 2015, the applicant is ineligible to obtain such coverage from Citizens if the premium for coverage from an authorized insurer is within 25 percent of the Citizens premium. A renewal policy is not eligible for citizens if it has a private market offer of coverage, including wind, at the private market insurer's approved rate.

Citizens Eligibility – Requirement to Purchase National Flood Insurance Program Coverage

If property is located in the Special Flood Hazard Area as defined by the National Flood Insurance Program (NFIP), a Citizens applicant or policyholder must maintain a separate flood insurance policy that has coverage limits for the building and contents equal to those provided under the Corporations' policy, subject to the maximum limits available under the National Flood Insurance Program. The requirement does not apply to tenants or condominium unit owners above the ground floor, a Citizens policy that excludes wind and hail coverage, a risk not eligible for flood coverage under the NFIP, or a mobile home located more than 2 miles from open water (ocean, gulf, bay, river, or the intracoastal waterway). The requirement to maintain flood insurance applies to new Citizens policies issued on or after January 1, 2012 and policies renewed on or after January 1, 2013.

Citizens Rates

The bill provides a statement of legislative intent that Citizens coverage be actuarially determined and not competitive with rates in the admitted voluntary market. Citizens rates should be those of a residual market mechanism that provides insurance only when it cannot be procured in the voluntary market. A Citizens rate filing made on or after July 1, 2011 must conform to the following requirements:

- *Mandatory Rate Increase* – Citizens must implement a rate increase each year for each residential line of business it writes of up to 20 percent by territory and 25 percent for any single policy. The mandatory rate increase expires January 1, 2015, and does not apply to rates for sinkhole coverage or costs for the purchase of private reinsurance. Under current law, Citizens must implement a yearly rate increase that does not exceed 10 percent for any single policyholder.
- *Annual Rate Filing* – Citizens must file its recommended rates with the Office of Insurance Regulation at least annually.
- *Industry Expense Equalization Factor* – Citizens must develop its rates using an industry expense equalization factor. The factor is designed to include within Citizens' rates standard insurance industry ratemaking expense provisions. The factor must include:
    - a catastrophe risk load;
    - a provision for taxes;
    - a market provision for reinsurance costs; and
    - an industry expense provision for general expenses, acquisition expenses, and commissions.
- *OIR Establishment of Rates* – The OIR must consider the recommended rates and issue a final order establishing the rates within 45 days after they are filed. Citizens may not pursue an administrative challenge or judicial review of the OIR's final order.
- *Prohibition Against Reducing Rates* – Citizens is prohibited from reducing rates.

The bill deletes the requirement that the public hurricane loss projection model must serve as the minimum benchmark for determining the windstorm portion of Citizens' rates. The bill also deletes provisions related to the current 10 percent mandatory rate increase, including a provision that sunsets the mandatory rate increase once Citizens has implemented actuarially sound rates for any line of business.

Citizens Coverage – Elimination of HO-3 Homeowners Policies

Citizens will not offer or renew HO-3 homeowners policies as of December 31, 2012. Instead, Citizens must offer a policy similar to what is available in the private insurance market under an HO-3, HO-4, or HO-6 policy. The prohibition on HO-3 coverage will result in Citizens using policy forms that provide coverage for fewer perils.

The HO-3 policy is an "all perils" homeowners policy that provides coverage to the structure for damage caused by any peril that is not specifically excluded from coverage and provides broad "named perils" coverage for damage to personal property. The HO-4 policy is a tenant's (renter's) insurance policy that provides "named peril" coverage for the personal property of tenants. The HO-6 policy is a condominium unit owner's policy that provides broad "named

peril" coverage for personal property and building components in which the policyholder has an insurable interest.

If Citizens replaces the HO-3 policy with a "named perils" policy form, it will make it more difficult for policyholders to prove they have sustained a covered loss. One of the key differences between an "all perils" policy and a "named perils" deals with which party has the burden of proof regarding whether the loss was caused by a covered peril. When property is insured by an all perils policy, the insurer has the burden of proof to show that the cause of damage was a peril that is excluded by the policy. However, when property is insured by a "named perils" policy, the policyholder has the burden of proving that the cause of damage was a peril for which the policy provides coverage.

Citizens Coverage – Cessation of New Commercial Nonresidential Policies

Citizens will cease accepting applications and issuing new policies for commercial nonresidential insurance once the bill becomes law. Current commercial nonresidential policies will remain in effect.

Citizens Coverage – Limitation on Sinkhole Coverage

New or renewal Citizens policies effective on or after January 1, 2012, that include the peril of sinkhole will not include coverage for losses to appurtenant structures (attached structures), driveways, sidewalks, decks, or patios directly or indirectly caused by sinkhole activity. Citizens may provide notice of the change to current policies by including a notice of coverage change with the policy renewal.

Citizens Deficit Assessments – Citizens Policyholder Surcharge

Citizens is prohibited from levying a regular assessment for a particular year's deficit until it has first levied the full amount of the Citizens policyholder surcharge (up to 15 percent of premium for each of the three Citizens accounts). The policyholder surcharge must be paid upon renewal, cancellation or termination of the policy. New Citizens policies issued within 12 months after the levy of the surcharge or the period of time necessary to collect the surcharge must also require payment of the policyholder surcharge.

Citizens Deficit Assessments – Emergency Assessments

The bill requires Citizens policyholders to pay Citizens emergency assessments that are 1.5 times the emergency assessment levied on subject lines of business in the private insurance market.

Citizens Deficit Assessments - Notice of Surcharge and Assessment Liability

As of January 1, 2012, an agent seeking to place coverage with Citizens must obtain a the applicant's signature on a written acknowledgement form notifying the applicant of the potential liability for surcharges and assessments placed on Citizens policyholders. If the acknowledgement form states that the policyholder understands that:

- If Citizens sustains a deficit, the policyholder could be subject to surcharges as high as 45 percent of premium.
- The policyholder is subject to emergency assessments to the same extent as policyholders of other insurance companies, or a different amount as imposed by the Legislature.
- Citizens is not supported by the full faith and credit of the state.

Citizens must maintain a copy of the signed acknowledgment form and send a copy to the policyholder upon the first renewal. The signed acknowledgment form creates a conclusive presumption the policyholder understood and accepted his or her potential surcharge and assessment liability.

Exemption from Bad Faith Liability and Extracontractual Damages

The bill clarifies existing law that Citizens is not liable for any claim for bad faith liability and that the Citizens statute and other provisions of law do not create a cause of action for bad faith or a claim for extracontractual damages. The bill states that the exemption from bad faith liability is part of the immunity from liability granted to the corporation and its agents, employees, board members, committee members and the OIR for actions taken by them in the performance of their duties or responsibilities under the Citizens statute. The bad faith exemption is premised on the fact that Citizens is a governmental entity that serves a public purpose.

Public Adjuster Prohibition

Policyholders are prohibited from engaging the services of a public adjuster with respect to any claim incurred under a policy issues by Citizens. The prohibition against retaining a public adjuster is a condition of coverage and made in recognition of Citizens' status as a government entity.

Agents – Eligibility for Appointment

Effective January 1, 2012, an insurance agent may only be appointed to be a licensed agent for Citizens if the agent holds an appointment with an authorized insurer that is actually writing personal lines residential property coverage in the state. Section 626.015(3), F.S., defines an "appointment" as authority given by an insurer or employer to a licensee to transact insurance or adjust claims on its behalf. Current law only requires that the agent have an appointment with a private market insurer that is currently writing coverage at the time of the agent's appointment with Citizens. Under the bill, an licensed Citizens agent can no longer represent it if the private market company that appointed the agent stops actively writing property coverage in Florida.

Agents – Grounds for Termination

Citizens must immediately terminate an agent's appointment to represent it if the Department of Financial Services determines that the agent violated s. 626.9541(1)(h), F.S. Section 626.9541(1)(h), F.S., prohibits unlawful rebates and defines such acts as an unfair insurance trade practice.

Citizens Governance – Outsourcing of Citizens Policy Issuance and Service Functions

The Citizens board of directors must commission an independent third-party consultant with expertise in insurance company management to issue a report that makes recommendations on the relative costs and benefits of outsourcing Citizens policy issuance and service functions to private servicing carriers or similar entities in the private market. The consultant must consider how other residual markets outsource appropriate functions or use servicing carriers. The report must be completed by February 1, 2012.

The board must develop a plan to implement the report and submit the plan to the Financial Services Commission. The commission has 30 days to review the plan and make any revisions. If the Commission approves the plan, the Citizens board of directors must begin implementing it by January 1, 2013.

Citizens Governance – Market Accountability Advisory Committee

The bill expands the function of the Market Accountability Advisory Committee to include providing advice in issues regarding agent appointments and compensation. Accordingly, the committee will include issues relating to producer compensation and agency agreements within the report it provides during each Citizens board meeting. The bill also clarifies that members of the committee are must be appointed for a 3-year term, but are not required to serve the entire term.

Citizens Governance – Conflict of Interest Procedures for Citizens Boardmembers

The bill provides procedures for board members who have a conflict of interest regarding a particular matter. A Citizens board member may not vote on any measure that would inure to the gain or loss of the board member; the board member's corporate principal or the parent or subsidiary of the corporate principal; or the relative or business associate of the board member. A board member with a conflict must state his or her interest in the matter prior to the vote being taken. The board member must also provide written disclosure of the conflict within 15 days after the vote, and the disclosure must be included in the minutes of the board meeting and available as a public record.

Repeal of Requirement to Reduce Citizens High-Risk Area

Risks located within Citizens' high-risk area are eligible for wind-only coverage from the corporation. The bill deletes the requirement that the Citizens board of directs must annually report to the legislature the reduction or increase in the 100-year probable maximum loss attributable to the combined PML of wind-only coverage and the Citizens quota-share program, when compared to the 100-year PML for the Florida Windstorm Underwriting Association as of February 2001 (the benchmark PML). The bill also deletes requirements that Citizens reduce the boundaries of the high-risk area. As of December 1, 2010, current law requires the Citizens board of directors to reduce the boundaries of the high-risk to the extent necessary to reduce the probably maximum loss attributable to wind-only coverages and the quota-share program to 25 percent below the benchmark PML. As of February 1, 2015, the high risk area boundaries must be further reduced to create a 50 percent PML reduction below the benchmark PML.

Repeal of the Citizens Quota Share Program

The bill deletes statutory authorization for Citizens to enter into quota share primary insurance agreements, as defined in s. 627.4025(2)(a), F.S., to provide hurricane coverage for risks eligible for coverage in the Citizens high-risk account. Quota share insurance is an agreement between Citizens and a private market insurer to provide insurance coverage in specified percentages.

Section 2. Amends s. 627.3511(4), F.S., makes technical, conforming changes related to the statutory changes in the bill.

Section 3. Amends s. 627.712(1), F.S., makes technical, conforming changes related to the statutory changes in the bill.

Section 4. This act is effective upon becoming a law.

Other Potential Implications:

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:

Citizens policyholders will be subject to a yearly rate increase of no more than 20% per territory and 25% per policy, not including rate increases attributable to sinkhole coverage or the purchase of private reinsurance. The requirement that Citizens use an industry expense equalization factor will also increase Citizens rates. The rate-increase requirements are intended to return Citizens to its original intended purpose as the property insurer of last resort. The rate increases should also improve the ability of Citizens to pay catastrophe claims out of its surplus and accelerate the depopulation of its policies into the private insurance market.

Citizens policyholders will be subject to emergency assessments levied by Citizens that are 1.5 times the emergency assessment levied on policyholder in the private market. The provision ensures that Citizens policyholders will face greater liability for such assessments than other policyholders.

All structures with a value of $1 million or more will be ineligible for Citizens coverage beginning in 2012. Policyholders in the personal lines account will be ineligible for Citizens coverage in 2014 if the structure has a value of $750,000 or more. In 2016, structures valued at $500,000 or more are ineligible. The owners of these properties will be forced to obtain coverage from the admitted insurance market or a largely unregulated surplus lines insurance carrier.

The prohibition on million dollar structures will also affect Citizens policyholders owning residences valued at over $1 million who complied with s. 627.736(a)5., F.S., which requires owners of $750,000 homes in the wind-borne debris region to purchase opening protections (i.e. shutters) in order to remain eligible as of January 1, 2009. Such policyholders will now be ineligible for Citizens if the residence is valued at $1 million or more.

Insureds located within a Special Flood Hazard Area as defined by the National Flood Insurance Program will be required to maintain a separate flood insurance policy as a condition of Citizens coverage. Such insureds will have additional protection from flood damage, which is excluded under the Citizens policy, but will have to incur additional cost.

Business owners who cannot procure commercial property insurance coverage in the admitted private insurance market will be ineligible to obtain such coverage from Citizens. This will likely necessitate the purchase of insurance from a nonadmitted surplus lines insurance carrier.

C. Government Sector Impact:

Citizens will likely incur expenses in replacing its current HO-3 homeowners insurance policy with an alternative policy form that is similar to coverage available in the private market. Citizens may benefit from outsourcing its policy issuance and service functions to private servicing carriers or similar entities if the private market can effectively perform these functions at a lower cost.

Clarification of Citizens existing exemption from bad faith liability will help ensure that the courts do not apply the civil remedy statute or common law bad faith liability to claims handled by Citizens.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 70 - 359
and insert:
(h) In all actions involving the Florida Motor Vehicle No-Fault Law, ss. 627.730-627.7407, where arbitration of an existing controversy is agreed to pursuant to s. 682.02 and the arbitration decision is challenged.

Section 2. Subsection (3) is added to section 627.4137, Florida Statutes, to read:

627.4137 Disclosure of certain information required.—

(3) Any request made to a self-insured corporation pursuant

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to this section shall be sent by certified mail to the registered agent of the disclosing entity.

Section 3. Present subsections (10), (11), and (12) of section 817.234, Florida Statutes, are renumbered as subsections (11), (12), and (13), respectively, and a new subsection (10) is added to that section, to read:

817.234 False and fraudulent insurance claims.—

(10) In addition to any criminal liability, a person convicted of violating any provision of this section for the purpose of receiving insurance proceeds from a motor vehicle insurance contract is subject to a civil penalty.

(a) Except for a violation of subsection (9), the civil penalty shall be:

1. A fine up to $5,000 for a first offense.

2. A fine greater than $5,000, but not to exceed $10,000, for a second offense.

3. A fine greater than $10,000, but not to exceed $15,000, for a third or subsequent offense.

(b) The civil penalty for a violation of subsection (9) must be at least $15,000, but may not exceed $50,000.

(c) The civil penalty shall be paid to the Insurance Regulatory Trust Fund within the Department of Financial Services and used by the department for the investigation and prosecution of insurance fraud.

(d) This subsection does not prohibit a state attorney from entering into a written agreement in which the person charged with the violation does not admit to or deny the charges but consents to payment of the civil penalty.

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

And the title is amended as follows:

Delete lines 10 - 44

and insert:

amending s. 817.234, F.S.; providing civil penalties for fraudulent insurance claims involving motor vehicle insurance; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 1694

INTRODUCER: Senator Richter

SUBJECT: Motor Vehicle Personal Injury Protection Insurance

DATE: March 27, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Pre-meeting**
2.			JU	
3.			BC	
4.				
5.				
6.				

I. Summary:

Senate Bill 1694 amends the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.). The bill requires any person seeking personal injury protection (PIP) benefits to comply with the terms of the insurance policy, including submitting to examinations under oath (EUO). The bill also creates a rebuttable presumption that a claimant's failure to appear for an independent medical examination is unreasonable, and specifies that the insurer is not liable for any PIP benefits incurred after the date of the first request for examination.

The bill specifies that the Medicare fee schedule in effect on January 1 applies for the rest of the calendar year. The bill also clarifies the maximum PIP reimbursement for durable medical equipment, care, and services rendered by a clinical laboratory and for medical care and services provided in an ambulatory surgical center.

The bill limits attorney's fees recovered pursuant to a No-Fault dispute to the lesser of $10,000 or three times the amount recovered. In a class action under the No-Fault law, attorney's fees are limited to the lesser of $50,000 or three times the recovery. The bill also prohibits using a contingency risk multiplier to calculate attorney's fees recovered under the No-Fault law.

The bill authorizes insurers to offer motor vehicle insurance policies that require or allow the arbitration of claims disputes over PIP benefits. The policy may require arbitration before filing a lawsuit and require that arbitration be used to resolve disputes in lieu of litigation. The arbitrator's decision is binding on each party, but may be challenged by either party in Circuit Court. The arbitration challenge is limited to a review of the record and not de novo review. If the insurer pays the arbitration award and the insured files a challenge in circuit court, the insured is not entitled to attorney's fees under s. 627.428, F.S., and interest will not accrue on the

amount in dispute during the litigation. The bill gives circuit courts original jurisdiction of all actions involving the No-Fault law that are not resolved through arbitration.

Written requests to a self-insured corporation for insurance policy information must be sent by certified mail to the corporation's registered agent.

This bill substantially amends the following sections of the Florida Statutes: 26.012, 627.4137, 627.731, and 627.736.

II. Present Situation:

Florida Motor Vehicle No-Fault Law

Under the state's no-fault law, owners or registrants of motor vehicles are required to purchase $10,000 of personal injury protection (PIP) insurance which compensates persons injured in accidents regardless of fault. Policyholders are indemnified by their own insurer. The intent of no-fault insurance is to provide prompt medical treatment without regard to fault. This coverage also provides policyholders with immunity from liability for economic damages up to the policy limits and limits tort suits for non-economic damages (pain and suffering) below a specified injury threshold. In contrast, under a tort liability system, the negligent party is responsible for damages caused and an accident victim can sue the at-fault driver to recover economic and non-economic damages.

Florida drivers are required to purchase both personal injury protection (PIP) and property damage liability (PD) insurance. The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person and $20,000 for bodily injuries to two or more people. Personal injury protection coverage provides reimbursement for 80 percent of reasonable medical expenses, 60 percent of loss of income, 100 percent of replacement services, for bodily injury sustained in a motor vehicle accident, without regard to fault. The property damage liability coverage must provide a $10,000 minimum benefit. A $5,000 death benefit is also provided.

In 2007, the Legislature re-enacted and revised the Florida Motor Vehicle No-Fault Law (ss. 627.730-627.7405, F.S.) effective January 1, 2008.[1] The re-enactment maintained personal injury protection (PIP) coverage at 80 percent of medical expenses up to $10,000. However, benefits are limited to services and care lawfully provided, supervised, ordered or prescribed by a licensed physician, osteopath, chiropractor or dentist; or provided by:

- A hospital or ambulatory surgical center;
- An ambulance or emergency medical technician that provided emergency transportation or treatment;
- An entity wholly owned by physicians, osteopaths, chiropractors, dentists, or such practitioners and their spouse, parent, child or sibling;
- An entity wholly owned by a hospital or hospitals;
- Licensed health care clinics that are accredited by a specified accrediting organization.

[1] *See* ch. 2007-324, L.O.F.

Medical Fee Limits for PIP Reimbursement

Section 627.736(6), Florida Statutes, authorizes insurers to limit reimbursement for benefits payable from PIP coverage to 80 percent of the following schedule of maximum charges:

- For emergency transport and treatment (ambulance and emergency medical technicians), 200 percent of Medicare;
- For emergency services and care provided by a hospital, 75 percent of the hospital's usual and customary charges;
- For emergency services and care and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community;
- For hospital inpatient services, 200 percent of Medicare Part A;
- For hospital outpatient services, 200 percent of Medicare Part A;
- For all other medical services, supplies, and care, 200 percent of Medicare Part B;
- For medical care not reimbursable under Medicare, 80 percent of the workers' compensation fee schedule. If the medical care is not reimbursable under either Medicare or workers' compensation then the insurer is not required to provide reimbursement.

The insurer may not apply any utilization limits that apply under Medicare or workers' compensation. Also, the insurer must reimburse any health care provider rendering services under the scope of his or her license, regardless of any restriction under Medicare that restricts payments to certain types of health care providers for specified procedures. Medical providers are not allowed to bill the insured for any excess amount when an insurer limits payment as authorized in the fee schedule, except for amounts that are not covered due to the PIP coinsurance amount (the 20 percent co-payment) or for amounts that exceed maximum policy limits.

Motor Vehicle Insurance Fraud

Recently, Florida has experienced an increase in motor vehicle related insurance fraud. The number of staged motor vehicle accidents received by the Division of Insurance Fraud (Division)[2] has nearly doubled from fiscal year 2008/2009 (776) to fiscal year 2009/2010 (1,461). The Division is also reporting sizeable increases in the overall number of PIP fraud referrals, which have increased from 3,151 during fiscal year 2007/2008 to 5,543 in fiscal year 2009/2010. Florida led the nation in staged motor vehicle accident "questionable claims"[3] from 2007-2009, according to the National Insurance Crime Bureau (NICB).[4]

Motor vehicle insurance fraud is a long-standing problem in Florida. In November 2005, the Senate Banking and Insurance Committee produced a report entitled Florida's Motor Vehicle No-Fault Law, which was a comprehensive review of Florida's No-Fault system. The report noted that fraud was at an "all-time" high at the time, noting that there were 3,942 PIP fraud

[2] The Division of Insurance Fraud is the law enforcement arm of the Department of Financial Services.
[3] The NICB defines a "questionable claim" as one in which indications of behavior associated with staged accidents are present. Such claims are not necessarily verified instances of insurance fraud.
[4] The National Insurance Crime Bureau is a not-for-profit organization that receives report from approximately 1,000 property and casualty insurance companies. The NICB's self-stated mission is to partner with insurers and law enforcement agencies.

referrals received by the Division during the three fiscal years beginning in 2002 and ending in 2005. That amount was easily exceeded by the over 5,500 PIP fraud referrals received by the division during the 2009/2010 fiscal year. Given this fact, the following description from the 2005 report is an accurate description of the current situation regarding motor vehicle insurance fraud:

> "Florida's no-fault laws are being exploited by sophisticated criminal organizations in schemes that involve health care clinic fraud, staging (faking) car crashes, manufacturing false crash reports, adding occupants to existing crash reports, filing PIP claims using contrived injuries, colluding with dishonest medical treatment providers to fraudulently bill insurance companies for medically unnecessary or non-existent treatments, and patient-brokering…

Fraudulent claims are a major cost-driver and result in higher motor vehicle insurance premium costs for Florida policyholders. Representatives from the Division have identified the following sources of motor vehicle insurance fraud:

- Ease of health care clinic ownership.
- Failure of some law enforcement crash reports to identify all passengers involved in an accident.
- Solicitation of patients by certain unscrupulous medical providers, attorneys, and medical and legal referral services.
- Litigation over de minimis PIP disputes.
- The inability of local law enforcement agencies to actively pursue the large amount of motor vehicle fraud currently occurring.

Examinations Under Oath

The standard motor vehicle insurance policy contains a provision requiring the insured or claimant to submit to an examination under oath (EUO) as often as the insurer may reasonably require. When an insurer seeks an EUO of an insured or claimant, it sends a written request setting forth the time, date, and location of the examination and a list of any documents that the insurer is requesting. The examination is similar to a legal deposition as the insured answers questions posed by the insurance company's attorney.

Medical providers and insurers dispute whether an insurer may require a medical provider who has accepted an assignment of benefits to submit to an examination under oath. The Fifth District Court of Appeals ruled in *Shaw v. State Farm Fire and Cas. Co*., 37 So. 3d 329 (Fla. 5th DCA 2010), that a medical provider who was assigned PIP benefits by its insured was not required to submit to an EUO. The court stated that under Florida law, the assignment of contract rights (here, to receive reimbursement for PIP medical benefits) does not entail the transfer of contract duties (to submit to an EUO) unless the assignee agrees to accept the duty. The court noted that the assignment does not extinguish the duty to comply with the insurance contract, but stated that it is the contracting party (the insured) who must comply with contract conditions. The majority decision also found that State Farm attempted to impermissibly alter via contract the state's No-Fault Law, which provides how insurers may obtain information from health care providers. A dissent in the case stated that the *Shaw* policy clearly stated that the medical provider must

submit to an EUO under the State Farm policy because it required each "claimant" to submit to an EUO. The dissent also stated that an assignment of benefits does not remove the assignee from the burden of compliance with contract conditions under Florida law.

Attorney Fee Awards

Pursuant to s. 627.428, F.S., parties that prevail against insurers in court, including PIP claimants, are entitled to an award of reasonable attorney fees. In determining a fee award, a court engages in a "Lodestar" calculation, which is the reasonable number of hours the attorney worked multiplied by a reasonable hourly rate.[5] In determining a reasonable fee, courts should consider the following factors set forth by the Florida Bar[6]:

- Time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service properly.
- The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.
- The fee customarily charged.
- The amount involved and the results obtained.
- The time limitations imposed.
- The nature and length of the professional relationship with the client.
- The experience, reputation, and ability of the lawyer(s) performing the services.
- Whether the fee is fixed or contingent.

In personal injury cases in which the prevailing claimant's attorney has worked on a contingency fee basis, it is within the court's discretion whether or not to use a contingency risk multiplier of up to 2.5 times the "Lodestar" amount in determining the fee award.[7] In federal cases, the use of a contingency risk multiplier in computing attorney fee awards under federal fee-shifting statutes was effectively eliminated in 1987.[8] A trial court has discretion regarding whether to apply a contingency risk multiplier, using the following criteria to determine whether a multiplier is necessary: (1) whether the relevant market requires a multiplier to obtain competent counsel; (2) whether the attorney could mitigate the risk of nonpayment; and (3) the amount involved, the results obtained, and the type of fee arrangement between the attorney and his client.[9] If the trial court determines that a multiplier is necessary, it may apply the following multipliers:

- A multiplier of 1 to 1.5 if success was more likely than not at the outset;
- A multiplier of 1.5 to 2.0 if the likelihood of success was approximately even at the outset;
- A multiplier of 2.0 to 2.5 if success was unlikely at the outset of the case.[10]

[5] See *Florida Patient's Compensation Fund v. Rowe*, 472 So. 2d 1145 (Fla. 1985).
[6] *See* R. Regulating Fla. Bar 4-1.5(b).
[7] See *Standard Guaranty Ins. Co. v. Quanstrom*, 555 So. 2d 828 (Fla. 1990).
[8] See *Pennsylvania v. Delaware Valley Citizens Council for Clean Air*, 483 U.S. 711 (1987).
[9] *See supra* note 8 at 834.
[10] *See id.*

Florida Arbitration Code

The Florida Arbitration Code (ss. 682.01-682.22, F.S.) authorizes two or more parties to agree in writing to resolve controversies between the parties in arbitration proceedings governed by the provisions of the code.[11] Agreements to arbitrate under the Florida Arbitration Code are valid, enforceable, and irrevocable.[12] A party to an arbitration agreement may petition a court for an order directing the parties to proceed with arbitration, and court actions involving issues governed by the arbitration agreement must be stayed upon a request for such an order.[13]

The arbitration agreement governs the method of selecting arbitrators, in which the court selects the arbitrators if the agreement is silent on the issue or the method in the arbitration agreement fails.[14] If multiple arbitrators are selected, an umpire may also be selected that will render the arbitration award if the arbitrators are unable to agree. The arbitration hearing may be governed by the arbitration agreement or the arbitration code, the latter of which directs the arbitrators to provide notice of the hearing, review evidence, and render a decision.[15] The parties are entitled to be heard during the arbitration hearing, to present material evidence, to cross examine witnesses, and to have an attorney present. The arbitration award must be in writing and signed by the arbitrators.[16] Under the Florida Arbitration Code, the arbitration award may only be appealed in limited circumstances[17], and an arbitration award may only be vacated because it was procured by corruption, fraud, or undue means; the arbitrators or umpire were corrupt or partial; the arbitrators or umpire exceeded their powers or improperly refused to continue a proceeding or hear material evidence; or there was no valid agreement to arbitrate.[18]

In 2000, the Florida Supreme Court decided *Nationwide Mutual Fire Ins. Co. v. Pinnacle Medical, Inc.*, 753 So.2d 55 (Fla. 2000), which invalidated a statutory provision that required medical providers that receive an assignment of benefits under the No-Fault law to enter arbitration and prohibited such providers from pursuing a breach of contract claim in court. The Court declared that the arbitration provision violated the right of medical providers to access courts pursuant to article I, section 21 of the Florida Constitution. The court had previously declared a statute constitutional that directed parties to resolve disputes via arbitration before filing an action in circuit court because the statute provided for a trial de novo[19] in circuit court for a party who appealed the arbitration award.[20] The court also noted that a statutory requirement that the arbitration board's decision be presumed correct in the trial de novo would raise serious concerns regarding the constitutionality of such a provision.[21]

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[11] See s. 682.02, F.S.
[12] *See id.*
[13] *See* s. 682.03, F.S.
[14] *See* s. 682.05, F.S.
[15] *See* s. 682.06, F.S.
[16] *See* s. 682.09, F.S.
[17] *See* s. 682.20, F.S.
[18] *See* s. 682.13, F.S. See *District School Board of St. Johns County v. Timoney*, 524 So. 2d 1129, 1131 (Fla. 5th DCA 1998); See *Prudential-Bache Securities, Inc. v. Shuman*, 483 So. 2d 888 (Fla. 3d DCA 1986).
[19] A "trial de novo" is a new trial on appeal in which the court determines the matter anew, and the prior adjudication has no weight.
[20] See *Chrysler Corporation v. Pitsirelos*, 721 So. 2d 710, 713 (Fla. 1998).
[21] *See supra* note 21 at 714.

III. Effect of Proposed Changes:

Section 1. Amends s. 26.012(2), F.S., which specifies the original jurisdiction of Circuit Courts.

Circuit Court Jurisdiction of PIP Disputes

The bill gives circuit courts original jurisdiction of all actions involving the No-Fault law that are not resolved through arbitration. Pursuant to s. 34.01, F.S., county courts have original jurisdiction of civil actions in which the matter in dispute does not exceed $15,000, not including interest, costs, and attorney's fees, except for disputes that are within the exclusive jurisdiction of the circuit court. Currently, county courts have original jurisdiction over many disputes involving the No-Fault law because the amount in controversy is less than $15,000.

Section 2. Amends s. 627.4137, F.S., which requires liability insurers to disclose coverage information. The bill requires that written requests to a self-insured corporation for insurance policy information must be sent by certified mail to the corporation's registered agent.

Section 3. Amends s. 627.731, F.S., which states the purpose of the Florida Motor Vehicle No-Fault Law.

Legislative Intent of the No-Fault Law

The bill provides a statement of legislative intent regarding the No-Fault Law. Three statements of legislative intent are provided:

- The provisions, schedules, and procedures authorized in the no-fault law are to be implemented by insurers and have full effect regardless of whether they are included in the insurance policy, and thus an insurer is not required to amend its policy form.
- Insurers should properly investigate claims. Accordingly, insurers may obtain examinations under oath and sworn statements from claimants seeking no-fault insurance benefits and may request mental and physical independent medical examinations of persons seeking PIP coverage or benefits.
- The insured's interest in obtaining competent counsel must be balanced with the public's interest in not encouraging PIP litigation because of exorbitant attorney's fees. Courts should limit attorney fee awards in order to eliminate incentives for attorneys to manufacture unnecessary litigation.

Section 4. Amends s. 627.736, F.S., governing PIP benefits. The bill makes the following changes:

Clarification of the PIP Fee Schedule

The PIP fee schedule utilizes the Medicare fee schedule in setting the maximum reimbursement that providers may obtain for many services and treatments. The bill requires use of the Medicare fee schedule in effect on January 1 of the year in which medical services, supplies, or care was provided.

The bill clarifies that the maximum reimbursement for durable medical equipment, care, and services rendered by a clinical laboratory is 200 percent of the Medicare Part B fee schedule. The bill also clarifies that the maximum reimbursement for medical care and services provided in an ambulatory surgical center is 80 percent of the maximum reimbursement available under the workers' compensation fee schedule.

Compliance with Policy Terms and Submission to Examinations Under Oath

The bill requires any person seeking benefits to comply with the terms of the insurance policy, including submitting to examinations under oath (EUO). Compliance with policy terms is a condition precedent to receiving benefits under the No-Fault law. However, insurers are prohibited from, as a general business practice, requesting EUOs in a manner inconsistent with the terms of the applicable insurance policy. When an insurer requests an EUO of a claimant or medical provider that has been assigned benefits by the claimant, the following statutory provisions apply:

- All claimants and medical providers must produce all documents requested by the insurer that are reasonably obtainable and allow them to be inspected.
- A medical provider that is requested to submit to an EUO must produce the persons having the most knowledge of the issues identified by the insurer in the request for examination.
- The EUO may be recorded by audio, video, and court reporter.

The provision is intended to reverse the Florida Third District Court of Appeal's decision in *Shaw*, 37 So.3d 329.

Unreasonable Failure to Submit to a Medical Examination [s. 627.736(7), F.S.]

Current law authorizes an insurer to require that an injured PIP claimant submit to a physical or mental examination conducted by a physician of the insured's choosing. If a person unreasonably refuses to submit to an examination, the insurance carrier is no longer liable for subsequent PIP benefits. The bill clarifies that the carrier is not liable for any PIP benefits incurred after the date of the first request for examination. The bill also creates a rebuttable presumption that the claimant's failure to appear for the examination was unreasonable. The bill makes submission to a physical or mental examination a condition precedent to receiving benefits.

The provision is intended to reverse the Florida Supreme Court's decision in *Custer Medical Center v. United Automobile Insurance Company*, 35 Fla. L. Weekly S640 (Fla. November 4, 2010). In *Custer*, the Court determined that the insurer must provide evidence that an insured's failure to appear (3 times) for a scheduled medical examination pursuant to s. 627.736(7), F.S., is unreasonable. Because an insured may reasonably refuse to attend a medical examination, the insured's failure to attend the medical examination does not establish that it was unreasonable. Under the *Custer* decision, the insurer cannot prevail on a summary judgment motion on the issue and instead must proffer evidence that the refusal was unreasonable.

Limitations on Attorney's Fees

The bill limits attorney's fees recovered pursuant to a No-Fault dispute to the lesser of $10,000 or three times the amount recovered. In a class action under the No-Fault law, attorney's fees are limited to the lesser of $50,000 or three times the recovery.

The bill also prohibits using a contingency risk multiplier to calculate attorney's fees recovered under the No-Fault law.

Arbitration of PIP Disputes

The bill authorizes insurers to offer motor vehicle insurance policies that require or allow the insurer or claimant to demand arbitration of claims disputes over PIP benefits. The policy may require the insurer or claimant to demand arbitration before filing a lawsuit and require that arbitration be used to resolve disputes in lieu of litigation. Arbitration will be subject to the Florida Arbitration Code, except as otherwise provided in the statute.

The arbitration process will be as follows:

- *Demand for Arbitration* – The arbitration demand must be in writing and mailed to the insurer or claimant by certified mail.
- *Timeframe and Location of Arbitration*:
    - Arbitration may not be initiated until 30 days after the request for arbitration is received and 20 days after documents are received from the claimant and insurer.
    - Arbitration shall take place in the county where treatment was rendered. If treatment was rendered outside Florida, arbitration shall take place in the insured's county of residence unless the parties agree to another location.
- *Selection of the Arbitrator* – The parties shall mutually agree to the selection of an arbitrator within 20 days. If the parties cannot agree, the arbitrator will be selected by the chief judge of the circuit in which the arbitration is pending.
- *Document Discovery in Arbitration*:
    - The insurer may request in writing that the claimant make the entire file (including medical records) pertaining to the insured who is the subject of arbitration available for inspection.
    - The claimant may request in writing prior to the arbitration that the insurer make the evidence upon which it is relying in adjusting or rejecting the claim available for inspection or copying. The claimant may only discover items related to insurance coverage. Discovery is not available pertaining to issues of potential bad faith claims handling, nor is discovery available for privileged items, underwriting files, or documents the insurer does not intend to rely on as evidence supporting its adjustment or rejection of the claim.
- *The Arbitration Decision*:
    - The arbitrator's decision is binding on each party, unless challenged. The decision must be furnished in writing to each party.
    - The arbitrator's award may not exceed the applicable coverage limits remaining on the policy.
- *Attorney's Fees* – Attorney's fees may be recovered by the claimant, but are limited to three times the lesser of $10,000 or three times the amount recovered.

- *Circuit Court Challenge of the Arbitration Award* – Either party may challenge the arbitration decision by filing a complaint in circuit court enclosing a copy of the arbitration decision. The arbitration challenge is limited to a review of the record and not de novo review.
- *Limits on Attorney's Fees and Interest During an Arbitration Award Challenge* – If the insurer pays the arbitration award and the insured files a challenge in circuit court, the insured is not entitled to attorney's fees under s. 627.428, F.S. In this circumstance interest on the amount in dispute will not accrue during the litigation.

Section 5. The act is effective upon becoming law.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The bill's authorization of insurance policies that require PIP disputes be submitted to arbitration may be unconstitutional pursuant to *Pinnacle Medical, Inc.*, 753 So. 2d 55. In *Pinnacle*, the Florida Supreme Court ruled unconstitutional a statute requiring medical providers to resolve PIP disputes through arbitration and prohibiting such providers from filing suit. Though the arbitration provision in this bill does not prohibit filing suit, the extremely limited grounds by which an arbitration award may be overturned (essentially a fraudulent proceeding) likely would be a violation of the right of access to courts guaranteed under the Florida Constitution. If appeal of arbitration via a trial de novo were provided, the arbitration provision should meet the standard articulated in the *Pinnacle* decision.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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 Banking and Insurance Committee

BILL: SB 1806

INTRODUCER: Senator Diaz de la Portilla

SUBJECT: Motor Vehicle Insurance

DATE: March 24, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Burgess	BI	**Pre-meeting**
2.			JU	
3.			TR	
4.			BC	
5.				
6.				

I. Summary:

The bill requires persons renting or leasing a motor vehicle for less than 1 year to provide proof of insurance coverage in the amount not less than $500,000 combined property damage and bodily injury liability. If the person renting or leasing the vehicle does not obtain or possess this coverage and is involved in an accident, the rental or leasing company would be liable in the amounts up to $100,000 per person, $300,000 per incident for bodily injury, $50,000 for property damage, and an additional $500,000 for economic damages arising from the use of the vehicle. The additional economic damages would be reduced by the amount recovered from the person who rented or leased the vehicle. Further, if the person renting or leasing the vehicle does not obtain or possess the $500,000 combined coverage and is involved in an accident, the rental or leasing company would also be liable for any amounts that were not able to be recovered from the person who rented or leased the vehicle. The bill exempts vehicles rented or leased for commercial purposes.

This bill substantially amends the following section of the Florida Statutes: 324.021.

II. Present Situation:

In 1999, the Legislature created s. 324.021(9)(b)2, F.S.,[1] which states:

> The lessor, under an agreement to rent or lease a motor vehicle for a period of less than 1 year, shall be deemed the owner of the motor vehicle for the purpose of determining liability for the operation of the vehicle or the acts of

[1] Ch. 99-225; s.28, L.O.F.

the operator in connection therewith only up to $100,000 per person and up to $300,000 per incident for bodily injury and up to $50,000 for property damage. If the lessee or the operator of the motor vehicle is uninsured or has any insurance with limits less than $500,000 combined property damage and bodily injury liability, the lessor shall be liable for up to an additional $500,000 in economic damages only arising out of the use of the motor vehicle. The additional specified liability of the lessor for economic damages shall be reduced by amounts actually recovered from the lessee, from the operator, and from any insurance or self-insurance covering the lessee or operator. Nothing in this subparagraph shall be construed to affect the liability of the lessor for its own negligence.

Graves Amendment

In 2005, Congress addressed the vicarious liability issue (meaning liability without fault) with regard to rental and leasing car companies, by passing 49 U.S.C. 30106, also known as the Graves Amendment. The Graves Amendment states:

(a) In general.-An owner of a motor vehicle that rents or leases the vehicle to a person (or an affiliate of the owner) shall not be liable under the law of any State or political subdivision thereof, by reason of being the owner of the vehicle (or an affiliate of the owner), for harm to persons or property that results or arises out of the use, operation, or possession of the vehicle during the period of the rental or lease, if:

(1) the owner (or an affiliate of the owner) is engaged in the trade or business of renting or leasing motor vehicles; and

(2) there is no negligence or criminal wrongdoing on the part of the owner (or an affiliate of the owner).

(b) Financial responsibility laws.-Nothing in this section supersedes the law of any State or political subdivision thereof-

(1) imposing financial responsibility or insurance standards on the owner of a motor vehicle for the privilege of registering and operating a motor vehicle; or

(2) imposing liability on business entities engaged in the trade or business of renting or leasing motor vehicles for failure to meet the financial responsibility or liability insurance requirements under State law.

(c) Applicability and effective date.-Notwithstanding any other provision of law, this section shall apply with respect to any action commenced on or after the date of enactment of this section without regard to whether the harm that is the subject of the action, or the conduct that caused the harm, occurred before such date of enactment.

Court Challenges

There have been several Florida court rulings holding that s. 324.021(9)(b)2, F.S., was not a "financial responsibility" law exempt from the Graves Amendment, which preempted state vicarious liability laws.[2] As a result of these decisions, Florida rental and leasing companies continue to be subject to the requirements of s. 324.021(7), F.S., "Proof of Financial Responsibly" which requires coverage amounts of $10,000 for bodily injury or death to one person, or $20,000 for bodily injury or death to two or more persons and $10,000 coverage for property damage. The $10,000/$20,000/$10,000 coverage amounts are the same minimum amounts that all vehicle owners must carry to register a vehicle in the State of Florida.

III. Effect of Proposed Changes:

The bill requires the lessee or renter to possess or obtain liability coverage in the amounts of $100,000 per person and up to $300,000 per incident for bodily injury and up to $50,000 for property damage. Section 627.7275(2)(b), F.S., requires auto insurance policies to be issued for a period of at least 6 months. As a result, opponents to the bill argue that a consumer wanting to rent a vehicle for one day could be forced to purchase a 6 month policy if the consumer does not already carry the required coverage set forth in the bill. If this is the case, tourists from other states and countries would be impacted by this requirement. Proponents argue that the leasing and rental car companies currently offer this coverage under the company's umbrella policy, but there is debate on whether a policy not issued in the name of the lessee or renter meets the requirements of the bill that the lessee or renter possess or obtain the coverage.

If a consumer does not wish to purchase the additional coverage limits of the bill, then the rental or leasing company will be liable for $100,000 per person and up to $300,000 per incident for bodily injury and up to $50,000 for property damage, and an additional $500,000 in economic damages arising out of the use of the motor vehicle. Furthermore, the rental/leasing company will be liable for "any amount" of damage not recovered from the person who leased the vehicle. Opponents of the bill argue that rental and leasing companies will not be able to afford the insurance necessary to cover the risk of being liable for "any amount" if a vast majority of their customers do not have the additional coverage. The additional coverage, whether purchased by the customer or by the rental or leasing company, will increase the cost of renting a car in Florida.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[2] *West v. Enterprise Leasing Co.*, 997 So.2d 1196 (Fla. 2d DCA 2008).
Blanks v. Enterprise Leasing Co., 17 So.3d 857 (Fla. 3d DCA 2009).
Caraker v. Hertz Corp., 11 Fla. L. Weekly 1004220 (Fla. March 23, 2011).
Vargas v. Enterprise Leasing Co., 993 So. 2d 614 (Fla. 4th DCA 2008).

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The Courts may find the provisions of this bill to be in violation of the Graves Amendment.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None

B. Private Sector Impact:

Persons injured by a driver of a leased or rented vehicle would have additional coverage to pay for expenses incurred as a result of such injuries.

Persons wanting to rent or lease a car for less than 1 year could be required to purchase insurance that would cause the cost of renting or leasing a vehicle to increase.

Rental and leasing companies could be liable for "any amount" not recovered from the person who did not have the required amounts of coverage when renting or leasing the vehicle. This could cause the prices of renting a car in Florida to increase, as rental car companies purchase additional liability insurance to cover the open-ended exposure.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

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 Banking and Insurance Committee

BILL:	SB 1500
INTRODUCER:	Senator Latvala
SUBJECT:	Foster Care Providers
DATE:	March 27, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Pre-meeting**
2.			CF	
3.			JU	
4.			BC	
5.				
6.				

I. Summary:

The Legislature established a community-based care system to strengthen community support and increase accountability for the state's child welfare program. The system began in 1996 when the Legislature required the establishment of a minimum of five pilot programs to privatize foster care and related services through contracts with established, community-based care (CBCs) agencies. By 2006, the Department of Children and Families (DCF) had implemented the community-based care model statewide by contracting with 20 CBCs or lead agencies.

Pursuant to s. 409.1671, F.S., the CBCs and their subcontractors are required to meet certain state and federal requirements, including the maintenance of specified levels of liability insurance. The bill provides the following changes relating to liability insurance and tort actions:

- The bill reduces the general liability insurance coverage requirements for CBCs and subcontractors to $500,000 per claim and a policy limit aggregate of $1.5 million from $1 million per claim and $3 million per incident.
- In tort actions against CBC lead agencies and subcontractors:
    - Limits economic damages recoverable per claimant to $500,000 and capped at $1.5 million for all claimants per incident from the current $1 million per liability claim. The bill also limits the total amount of economic damages recoverable by all claimants to $2 million against a CBC and all subcontractors involved in the same incident.
    - Limits noneconomic damages to $200,000 per claimant and $500,000 per incident. The bill also limits the total amount of noneconomic damages

recoverable by all claimants to $1 million against a CBC and all subcontractors involved in the same accident.

- The bill requires DCF to use diligent efforts to ensure delivery of contracted services.
    - Provides that the DCF is not liable in tort for acts or omissions of a lead agency, or a subcontractor of the lead agency, or the officers, agents, or employees of the lead agency or subcontractor.
    - Prohibits the DCF from requiring a lead agency or a subcontractor to indemnify DCF against the DCF's own acts or omission.
    - Prohibits the DCF from requiring a lead agency or subcontractor to include the DCF as an additional insured on any insurance policy.

This bill substantially amends section 409.1671 of the Florida Statutes.

II. Present Situation:

Overview of Community-Based Care System in Florida

The Legislature created the community-based care system to strengthen community support and increase accountability for the child welfare program. The Legislature found that the purpose of such outsourcing "is to increase the level of safety, security, and stability of children who are or become the responsibility of the state."[1] Pursuant to s. 409.1671(e), F.S., the DCF is required to contract with a single agency, referred to as an "eligible lead community-based provider," for the provision of child protective services in a community. Under this current system, lead agencies are responsible for providing foster care and related services, including family preservation, emergency shelter, and adoption. A competent lead agency must:

- Have the ability to coordinate, integrate, and manage all child protective services in the designated community, and to ensure continuity of care.
- Provide directly, or contract for through a local network of providers, no more than 35 percent of all child protective services.
- Accept accountability for meeting all related state and Federal outcome standards, and serve all children referred, regardless of the level of funding allocated to the community by the state.

The DCF is responsible for program oversight, operating the abuse hotline, child protective investigations, and the provision of child welfare legal services. Pursuant to s. 409.1671(2)(a), F.S., the DCF is responsible for contracting for the delivery, administration, or management of protective services, foster care, and other related services or programs, as appropriate. The DCF has the responsibility for the quality of contracted services and programs and is responsible for ensuring that services are delivered in accordance with applicable federal laws and regulations as well as state laws and contractual agreements. Notwithstanding the outsourcing of foster care and related services, the DCF retains custody of the children in foster care and remains responsible for the services they are provided.

[1] Section 409.1671(1)(f), F.S.

Overview: Commercial General Liability and Professional Liability Insurance
A commercial general liability policy insures for bodily injury to a third party caused by the insured and loss damage to property owned by third parties caused by the insured. Typically, a general liability policy limits the amount the insurer will pay for each claim for each person (a per-occurrence limit) or the total amount for the policy period (an aggregate limit). Professional liability insurance provides coverage for claims arising from a professional's faulty services or failure to meet the standard of service expected under the circumstances.

An additional insured is a person added to a policy as an insured but not as a named insured. Generally, ISO[2] endorsements furnish coverage to the additional insured for liability arising out of the named insured's work, operations, or premises.[3] Once a party becomes an additional insured, the insurer is obligated to defend and indemnify that additional insured in accordance with the policy terms and conditions.[4]

Liability Insurance Requirements for Lead Agencies and Subcontractors
Section 409.1671(h) and (j), F.S., requires lead agencies and their subcontractors to provide general liability insurance coverage as well as automobile insurance coverage. Lead agencies and subcontractors are required to maintain a minimum level of general liability insurance of $1 million per claimant and $3 million per incident. In addition to the mandatory liability insurance limits, current law allows for a yearly increase of 5 percent in the conditional limitation on damages available to claimants to account for the annual increase in the cost of goods and services. Economic[5] damages per claimant are capped at $1,550,000.[6] Noneconomic[7] damages per claimant are capped at $310,000.[8]

In addition to the statutory insurance requirements, the DCF also requires CBCs to maintain professional liability insurance and to name the DCF as an additional insured. The statutory and contractual coverage requirements do not appear to be risk-based since the minimum levels of coverage do not appear to take into consideration the size or volume of services provided by a particular CBC.

The limits on liability provided for lead agencies and their subcontractors are not applicable if the lead agency or the subcontractor "acts in a culpably negligent manner or with willful and

[2] The Insurance Services Office (ISO) is an organization that produces standard insurance forms. In Florida, forms and rates require approval by the Office of Insurance Regulation pursuant to the insurance code.
[3] What Does an Additional Insured Endorsement Cover? http://www.irmi.com/expert/articles/2000/postel07.aspx (last visited March 27, 2011).
[4] Last, William C., *Additional Insured Endorsements Revisited.* http://www.lhfconstructlaw.com/CM/Articles/Articles121.asp (Last visited March 27, 2011).
[5] *See, e.g.,* s. 766.202(3), F.S., defining "economic damages" as financial losses that would not have occurred but for the injury giving rise to the cause of action in tort, including, but not limited to, past and future medical expenses, wage loss, loss of future earnings capacity, funeral expenses, and loss of prospective net accumulations of an estate.
[6] The original limit on economic damages was set at $1,000,000, in ch. 2009-206, L.O.F. The current limit on economic damages includes the annual 5 percent increase allowed by law.
[7] *See, e.g.,* s. 766.202(8), F.S., defining "noneconomic damages" as non-financial losses that would not have occurred but for the injury giving rise to the cause of action in tort, including, but not limited to, pain and suffering, loss of support and services, loss of companionship or consortium, inconvenience, physical impairment, mental anguish, disfigurement, and loss of capacity for enjoyment of life.
[8] The original limit on noneconomic damages per claimant was set at $200,000 in ch. 2009-206, L.O.F. The current limit on noneconomic damages includes the annual 5 percent increase allowed by law.

wanton disregard or unprovoked physical aggression when such acts result in injury or death or such acts proximately cause such injury or death…"[9] Culpable negligence is defined as "reckless indifference or grossly careless disregard of human life."[10] Further, the statute authorizes "a claim bill may be brought on behalf of a claimant pursuant to s. 768.28 for any amount exceeding the limits" provided to lead agencies and their subcontractors.[11]

Each contract with a CBC provider is required to provide for the payment by the DCF to the provider of a reasonable administrative cost in addition to funding for the provision of services pursuant to s. 409.1671, F.S. Administrative costs would generally include operating costs such as insurance premiums.

Division of Risk Management of the Department of Financial Services
The division is responsible for the management of claims reported by or against state agencies for coverage under the self-insurance fund known as the "State Risk Management Trust Fund." The division has the responsibility of investigating, evaluating, negotiating, defending, and making appropriate disposition of claims/lawsuits filed against the state because of a negligent act or omission. Investigations of claims are conducted by staff and/or in concert with a contracted adjusting service. Defense of litigated claims is provided by the Attorney General's Office, contract law firms, or state agency attorneys.

General liability coverage is one of the types of coverage provided through the trust fund. For purposes of general liability coverage, the state is liable for damages for injury, death, or loss of property caused by the negligence of its employees, agents or volunteers while acting within the course and scope of their employment or responsibilities. The self-insurance coverage includes premises and operations, personal injury, and professional liability. In accordance with s. 768.28, F.S., the limits of liability (under the waiver of sovereign immunity law) are $100,000 per person's claim, $200,000 per occurrence for all claims.

The division provides coverage to the DCF for claims from foster children alleging negligence or civil rights violations relating to their care. Prior to the creation of CBC's and the privatization of foster care, the DCF provided all foster care services. The division does not provide coverage to the CBC's or their subcontractors. Consequently, the division does not have any data on how many claims the CBC's or their subcontractors have received or paid since their creation.

III. Effect of Proposed Changes:

Section 1 amends s. 409.1671, F.S., relating to liability insurance requirements and limits of liability for CBCs, CBC subcontractors, and the DCF.

The bill reduces the mandatory general liability insurance coverage requirement for lead agencies and subcontractors to $500,000 per claim and a policy limit aggregate of $1.5 million from $1 million per claim and $3 million per incident.

[9] Section 4909.1671(1)(i) and (k), F.S.
[10] *Id.*
[11] Section 409.1671(1)(h) and (j), F.S.

The limit on economic damages available to a claimant is reduced to $500,000 per claim and capped at $1.5 million for all claimants per incident from $1 million per liability claim. The total amount of economic damages recoverable by all claimants is limited to $2 million against a CBC and all subcontractors involved in the same incident.

The bill also limits noneconomic damages to $200,000 per claimant and $500,000 per incident. Currently, the noneconomic damages are limited to $200,000 per claim. The bill limits the total amount of noneconomic damages recoverable by all claimants to $1 million against a lead agency and all subcontractors involved in the same incident.

The bill repeals s. 409.1671(1)(l), F.S., thereby eliminating the 5 percent annual increase in the conditional limitations on economic and noneconomic damages.

The bill adds language to s. 409.1671(2)(a), F.S., to provide that the DCF is not liable in tort for the acts or omissions of a lead agency, or a subcontractor of a lead agency, or the officers, agents, or employees of a lead agency, or subcontractor of a lead agency. The DCF may not require a lead agency or subcontractor of a lead agency to indemnify the department for its own acts or omissions. Lastly, the department may not require a lead agency or subcontractor to include the department as an additional insured on any insurance policy.

The bill deletes legislative findings that the minimum levels of insurance were to be in excess of the rights of recovery under s. 768.28, F.S.

Section 2 provides that the bill will take effect July 1, 2011.

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:

Lower liability insurance limits should reduce insurance premiums for the CBCs and subcontractors. The elimination of the DCF as an additional insured may result in some indeterminate reduction in premiums for the CBCs.

The lower liability insurance requirements may limit the amount of money claimants can recover from CBCs and subcontractors.

C. Government Sector Impact:

According to the Division of Risk Management of the Department of Financial Services (DFS), the lower liability insurance requirements could result in foster children and their attorneys seeking more money from the state either in claims settlements or in claims bills. The DFS provided the following comments:

> "The bill reduces the amounts of general liability insurance a CBC is required to carry, it also reduces the amounts a claimant can recover for economic and non-economic damages. If a claimant can recover sufficient money from a CBC, they are less likely to press their claim against DCF and Risk Management or to file a claims bill against DCF."[12]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 409.1671, F.S., requires lead community-based providers and subcontractors to obtain general liability insurance. Commercial general liability insurance only covers bodily injury and property damage arising out of an accident and generally excludes coverage for the abuse, neglect, and other types of errors and omissions claims to which lead community-based providers and subcontractors are exposed. Generally, professional liability insurance is required to cover these risks. However, the statute does not mandate such coverage.

Under current law, insurers of lead community-based providers' and subcontractors are not required to give the DCF written notice of any cancellation or nonrenewal and the lead community-based providers are not required to provide the DCF with copies of policies, endorsements, and certificates. The DCF needs notification of any cancellation or nonrenewal of a CBC policy and copies of policies, endorsements, and certificates in order to monitor compliance by the lead community-based providers and subcontractors with the statutory insurance coverage requirements. Gaps in coverage and other noncompliance by a CBC could result in liability exposure for the DCF.

Pursuant to s. 627.4133, F.S., an insurer is required to provide notice to the named insured at least 45 days prior to nonrenewal, cancellation, or termination. There are provisions in law

[12] Department of Financial Services Bill Analysis of SB 1500, dated March 9, 2011.

requiring an insurer to provide notice of a cancellation or nonrenewal to someone other than the named insured. For example, s. 440.05(7) F.S., allows a contractor to register in writing with the workers' compensation carrier for any subcontractor and receive written notice from the insurer of any cancellation or nonrenewal.

VIII. Additional Information:

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

None.

B. Amendments:

None.