SB 436 by **Altman (CO-INTRODUCERS) Soto**; (Identical to H 0459) Payment for Services Provided by Licensed Psychologists

CS/SM 1298 by **MS, Brandes**; (Similar to H 1169) Disaster Savings Account Act

SB 1354 by **Grimsley**; (Compare to CS/H 1001) Health Care

155310	A	S		BI, Detert	Delete L.159 - 167:	03/31 03:12 PM
383102	A	S		BI, Detert	Delete L.253 - 261:	03/31 03:12 PM

SB 1494 by **Thrasher**; (Similar to H 0187) Civil Remedies Against Insurers

SB 1580 by **Hays**; (Similar to CS/H 1351) Reimbursement Allowances for Hospital Care

809718	D	S	RCS	BI, Hays	Delete everything after	04/01 04:09 PM
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The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Simmons, Chair
Senator Clemens, Vice Chair

MEETING DATE: Tuesday, April 1, 2014
TIME: 3:00 —6:00 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Simmons, Chair; Senator Clemens, Vice Chair; Senators Benacquisto, Detert, Diaz de la Portilla, Hays, Lee, Margolis, Montford, Negron, Richter, and Ring

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 436** Altman (Identical H 459)	Payment for Services Provided by Licensed Psychologists; Adding licensed psychologists to the list of health care providers who are protected by a limitations period from claims for overpayment being sought by health insurers or health maintenance organizations, subject to a limitations period for submitting claims to health insurers or health maintenance organizations for underpayment, and eligible for direct payment for medical services by a health insurer under certain circumstances, etc. BI 04/01/2014 Favorable HP AHS AP	Favorable Yeas 11 Nays 0
2	**CS/SM 1298** Military and Veterans Affairs, Space, and Domestic Security / Brandes (Similar HM 1169)	Disaster Savings Account Act; Urging Congress to pass the Disaster Savings Account Act to encourage the mitigation of property damage and costs before a natural disaster strikes, etc. MS 03/19/2014 Fav/CS BI 04/01/2014 Favorable	Favorable Yeas 11 Nays 0
3	**SB 1354** Grimsley (Compare CS/H 1001)	Health Care; Revising contract requirements for managed care programs; prohibiting retroactive denial of claims in certain circumstances; establishing a process for providers to override certain treatment restrictions; requiring insurers to post preferred provider information on a website, etc. HP 03/25/2014 Favorable BI 04/01/2014 Temporarily Postponed	Temporarily Postponed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1494** Thrasher (Similar H 187)	Civil Remedies Against Insurers; Requiring insureds and claimants, or persons acting on their behalf, to provide an insurer with written notice of loss as a condition precedent to bringing a statutory or common-law action for a third-party bad faith action for failure to settle an insurance claim; providing that an insurer is not liable for such claim if certain conditions are met, etc. BI 04/01/2014 Temporarily Postponed JU RC	Temporarily Postponed
5	**SB 1580** Hays (Similar CS/H 1351)	Reimbursement Allowances for Hospital Care; Modifying reimbursement allowance rates; providing that the maximum reimbursement allowance for inpatient hospital care is a specified percentage of the rate allowed under the Medicare hospital inpatient prospective payment system; providing that compensable charges for hospital outpatient care is a specified percentage of the rate allowed under the Medicare hospital outpatient prospective payment system, etc. BI 04/01/2014 Fav/CS HP AP	Fav/CS Yeas 9 Nays 2
	Presentation on Title Insurance		Discussed
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 436
INTRODUCER:	Senators Altman and Soto
SUBJECT:	Payment for Services Provided by Licensed Psychologists
DATE:	March 31, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Favorable**
2.			HP	
3.			AHS	
4.			AP	

I. Summary:

SB 436 adds licensed psychologists to the list of non-network providers who are eligible for direct payment for medical services by a health insurer. The bill also adds licensed psychologists to the list of health care providers who are protected by a 12-month limitation period from claims for overpayment sought by health insurers or health maintenance organizations (HMOs) and adds licensed psychologists to the list of health care providers subject to a 12-month time period for submitting claims for underpayment against health insurers or HMOs.

II. Present Situation:

Claims of Overpayment and Underpayment

Under s. 627.6131(6), F.S., and s. 641.3155(5), F.S., respectively, health insurers and HMOs generally must submit any claim for overpayment to a health care provider within 30 months from the date of payment to the provider. The provider then has a specified time frame within which to pay the overpayment or contest the claim.[1] Under s. 627.6131(18), F.S., and s. 641.3155(16), F.S., however, a health insurer or HMO must submit a claim for overpayment against a health care provider licensed under chapters 458 (physicians), 459 (osteopaths), 460 (chiropractors), 461 (podiatrists), and 466 (dental surgeons) within 12 months after the payment of the claim.

Under s. 627.6131(19), F.S., and s. 641.3155(17), F.S., respectively, a health care provider licensed under chapters 458, 459, 460, 461, and 466 must submit any claim of underpayment within 12 months after receiving payment from the insurer or HMO.

[1] s. 627.6131(6)(a)(1), F.S., and s. 627.6131(6)(a)(2), F.S.

Practice of Psychology

Chapter 490, F.S., the "Psychological Services Act," governs the practice of psychology and school psychology in Florida. A person desiring to practice psychology or school psychology in Florida must be licensed by the Department of Health. "Practice of psychology" means the observation, description, evaluation, interpretation, and modification of human behavior by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior, and of enhancing interpersonal behavioral health and mental or psychological health.[2] "Practice of school psychology" means the rendering or offering to render to an individual, a group, an organization, a government agency, or the public any of the following services-assessment, counseling, consultation, and development of programs.[3]

Psychologists who contract as preferred providers[4] or network providers with an insurer receive payment directly from the insurer for the services rendered.[5] Until legislation passed in 2009,[6] however, non-network psychologists were generally paid by the insured. After paying the psychologist, the insured then would file a claim for reimbursement with his or her insurer. In contrast, even prior to 2009, Florida law required that for non-network recognized hospitals, licensed ambulance providers, physicians, and dentists who provided services to the insured in accordance with the provisions of the insurance policy, the insurer must directly reimburse the provider if the insured specifically authorized payment of benefits directly to the provider.[7]

Assignment of Benefits for Health Insurance Claims

Prior to the 2009 Legislative Session, s. 627.638(2), F.S., required that, when specifically authorized by the insured, a health insurer was required to make direct payment to any recognized hospital, licensed ambulance provider, physician, or dentist, unless "otherwise provided in the insurance contract." The pre-2009 law further provided that an insurance contract had to provide for the option of direct payment to a licensed hospital, licensed ambulance provider, physician, or dentist for emergency services or emergency medical transportation services.

In 2009, the Legislature amended s. 627.638(2), F.S., to remove the qualifying language: "otherwise provided in the insurance contract." The amending language also added "other person[s] who provided the services in accordance with the provisions of the policy" to the list of specified professionals who are entitled to direct payment if specifically authorized by the insured.[8] The effect of this legislation was to require that, if specifically authorized by the insured, a health insurer must directly pay all licensed hospitals, licensed ambulance providers,

[2] s. 490.003(4), F.S.
[3] s. 490.003(5), F.S.
[4] s. 627.6471(1)(b), F.S. It defines preferred provider as, "any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment…"
[5] s. 627.638(3), F.S.
[6] Ch. 2009-124, L.O.F.
[7] s. 627.638(2), F.S.
[8] Ch. 2009-124, L.O.F.

physicians, dentists, and other persons who provide services in accordance with the provisions of the insurance policy.

Due to concerns that these provisions might lead to increased costs to the state's group health plan as a result of providers leaving the network,[9] language was included in ch. 2009-124, L.O.F., providing for the amendments to be automatically repealed on July 1, 2012, and the language in s. 627.638(2), F.S., to revert to the language that existed on June 30, 2009, if the Office of Program Policy Analysis and Government Accountability (OPPAGA) made certain findings in a study to be published on or before March 1, 2012. The language was to be repealed if the OPPAGA found that:

- The amendments caused the third-party administrator of the state's group health plan to suffer a net loss of physicians from its preferred provider plan network; and
- As a direct result, the state's group health plan incurred an increase in costs.[10]

In January 2012, the OPPAGA issued the requisite report. The report found that since December 2009, the number of physicians participating in Blue Cross and Blue Shield of Florida's (BCBS) preferred provider network for the state group increased by 12.5 percent. In addition, while the number and amount of non-network physician and other profession claims increased slightly since 2009, the proportion of these claims to overall physician and other profession claims for the state group remained at about 2 percent. Moreover, the discount BCBS rates with network providers for the state group remained relatively unchanged. Overall costs for state group health participants were found to have increased, however, these increased costs could not be directly linked to the 2009 law because many factors contribute to rising health care costs.[11]

III. Effect of Proposed Changes:

Section 1 amends s. 627.6131, F.S., relating to overpayment or underpayment of claims by health insurers to a provider, to include psychologists and school psychologists in the list of providers:

- To whom an insurer must submit a claim for overpayment within 12 months after the health insurer's payment of the claim; and
- Who must submit a claim for underpayment to an insurer within 12 months after the health insurer's payment of the claim.

Section 2 amends s. 641.3155, F.S., relating to overpayment or underpayment of claims by an HMO to a provider, to include psychologists and school psychologists in the list of providers:

- To whom an insurer must submit a claim for overpayment within 12 months after the health insurer's payment of the claim; and

[9] Generally, an insurer will permit the policyholder to make an assignment of benefits for direct payment to providers with whom the insurer has contracted to be part of a network such as a Preferred Provider Organization (PPO). The ability to receive direct payment from the insurer is one of the reasons health care providers agree to become part of a preferred provider network, often in exchange for a reduced payment from the insurer.
[10] S. 2, ch. 2009-124, L.O.F.
[11] The Florida Legislature, Office of Program Policy Analysis and Government Accountability, *Negative Effects on the State's Third Party Provider Network from 2009 Law Not Apparent*, Report No. 12-01, January 2012, pages 2 and 4, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1201rpt.pdf (last viewed March 28, 2014).

- Who must submit a claim for underpayment to an insurer within 12 months after the health insurer's payment of the claim.

Section 3 amends s. 627.638(2), F.S., to include non-network psychologists in the specified list of providers:

- To whom an insurer must make direct payment, if the insured specifically authorizes the payment of benefits directly to a recognized hospital, licensed ambulance provider, physician, dentist, psychologist, or other person who provided the services in accordance with the policy;
- For which an insurance contract may not prohibit the direct payment of benefits; and
- For which an insurer must provide a claim form with an option for direct payment of benefits.

Section 4 provides an effective date of July 1, 2014.

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:

Psychologists will have a quicker turnaround time for receiving claims for overpayment from insurers or HMOs.

Health insurance carriers and HMOs will incur some administrative costs for revising health insurance forms to allow for the selection of a psychologist for direct payment for services rendered for hospital and emergency medical services.

C. Government Sector Impact:

The Office of Insurance Regulation anticipates an increase in health form review as a result of the additional category of providers eligible for direct payment on any health insurance form, but the increased form review can be absorbed within current resources.[12]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 627.638(2), F.S., requires that, if specifically authorized by the insured, a health insurer must directly pay all licensed hospitals, licensed ambulance providers, physicians, dentists, and "other person[s] who provide services" in accordance with the provisions of the insurance policy. The term "other person who provided the services" appears to be a catch-all provision that covers all health care providers, including psychologists.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6131, 641.3155, 627.638.

IX. Additional Information:

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

None.

B. Amendments:

None.

[12] Florida Office of Insurance Regulation, Legislative Affairs, *HB 1237*, March 13, 2013, page 3 (on file with Health Innovation Subcommittee staff).

By Senator Altman

16-00288-14 2014436__

A bill to be entitled

An act relating to payment for services provided by licensed psychologists; amending ss. 627.6131 and 641.3155, F.S.; adding licensed psychologists to the list of health care providers who are protected by a limitations period from claims for overpayment being sought by health insurers or health maintenance organizations; adding licensed psychologists to the list of health care providers who are subject to a limitations period for submitting claims to health insurers or health maintenance organizations for underpayment; amending s. 627.638, F.S.; adding licensed psychologists to the list of health care providers who are eligible for direct payment for medical services by a health insurer under certain circumstances; making technical and grammatical changes; providing an effective date.

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

Section 1. Subsections (18) and (19) of section 627.6131, Florida Statutes, are amended to read:

627.6131 Payment of claims.—

(18) Notwithstanding the 30-month period provided in subsection (6), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health insurer's payment of the claim. A claim for overpayment is ~~may~~ not ~~be~~ permitted

16-00288-14 2014436__

~~beyond~~ 12 months after the health insurer's payment of a claim, except that claims for overpayment may be sought after ~~beyond~~ that time from providers convicted of fraud pursuant to s. 817.234.

(19) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the insurer within 12 months after the health insurer's payment of the claim. A claim for underpayment is ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after the health insurer's payment of a claim.

Section 2. Subsections (16) and (17) of section 641.3155, Florida Statutes, are amended to read:

641.3155 Prompt payment of claims.—

(16) Notwithstanding the 30-month period provided in subsection (5), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. A claim for overpayment is ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought after ~~beyond~~ that time from providers convicted of fraud pursuant to s. 817.234.

(17) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, ~~or~~ chapter 466, or chapter 490 must be submitted to the health maintenance organization within 12 months after the health maintenance

organization's payment of the claim. A claim for underpayment is ~~may~~ not ~~be~~ permitted ~~beyond~~ 12 months after the health maintenance organization's payment of a claim.

Section 3. Subsection (2) of section 627.638, Florida Statutes, is amended to read:

627.638 Direct payment for hospital, medical services.—

(2) If ~~Whenever~~, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to a ~~any~~ recognized hospital, licensed ambulance provider, physician, dentist, psychologist, or other person who provided the services in accordance with ~~the provisions of~~ the policy, the insurer shall make such payment to the designated provider of such services. The insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, licensed ambulance provider, physician, dentist, psychologist, or other person who provided the services in accordance with ~~the provisions of~~ the policy for care provided. The insurer may require written attestation of assignment of benefits. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.

Section 4. This act shall take effect July 1, 2014.

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/1/2014
Meeting Date

Topic Insurance Payment for Psychologists Bill Number 436 *(if applicable)*

Name Connie Galietti Amendment Barcode _____ *(if applicable)*

Job Title Executive Director FL Psychological Assoc.

Address 408 Office Plaza Dr. Phone 850-656-2222
Street

Tallahassee FL 32301 E-mail connie@flapsych.com
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Representing FL Psychological Assoc.

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

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

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

S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SM 1298
INTRODUCER:	Military and Veterans Affairs, Space, and Domestic Security and Senator Brandes
SUBJECT:	Disaster Savings Account Act
DATE:	March 31, 2014 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Ryon/Spaulding	Ryon	MS	**Fav/CS**
2.	Matiyow	Knudson	BI	**Favorable**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SM 1298 urges Congress to pass the Disaster Savings Account Act of 2014. The Act would allow homeowners the ability to establish a tax-free savings account. The funds from the account are to be used for the costs of mitigation expenses intended to improve a home's resistance to storm damage.

II. Present Situation:

According to the Florida Division of Emergency Management, Florida may be considered the most vulnerable state in the nation to the impacts from hurricanes, tropical storms, and tropical depressions. In addition to hurricanes, the State of Florida is vulnerable to numerous other types of severe weather such as tornadoes, drought, various types of flooding, and extreme temperatures, including freezes. The vulnerable geography and environment of the state combined with the subtropical climate create continuous threats from these severe weather events.[1]

[1] Florida Division of Emergency Management. *The State of Florida Tropical and Non-Tropical Severe Weather Annex to the 2012 Florida Comprehensive Emergency Management Plan*. Available at: http://www.floridadisaster.org/documents/CEMP/2012/Tropical%20and%20Non-Tropical%20Severe%20Weather%20Annex%20-%2012.20.11.pdf (Last viewed March 28, 2014).

Florida is ranked as the fifth highest state with regard to the number of Federal Disaster Declarations[2] in the last 60 years.[3] As a result of Florida's high risk, Florida:

- Has over 2 million flood insurance policies issued by the National Flood Insurance Program.[4] Florida's 2 million policies account for approximately 37 percent of the total policies issued by the flood program nationwide.
- In 2011, was ranked as the most expensive state for homeowners insurance, with an average expenditure of $1,933.[5]
- Has the highest number of properties at potential risk for hurricane-driven storm surge,[6] more than 1.4 million properties valued at more than $386 billion.[7]
- Had a total value of coastal exposure at nearly $2.9 trillion in 2012, which far exceeded the combined coastal exposure of the other gulf region states,[8] with 1.6 trillion.[9]
- Had six of the twelve most costly hurricanes in insurance history impact the state:[10]
  - Hurricane Andrew (1992): $25.6 billion.
  - Hurricane Jeanne (2004): $5.6 billion.
  - Hurricane Francis (2004): $5.6 billion.
  - Hurricane Charley (2004): $9.2 billion.
  - Hurricane Wilma (2005): $11.1 billion.
  - Hurricane Katrina (2005): $48.7 billion.[11]

Disaster Mitigation

Mitigation is the effort to reduce the loss of life and property by lessening the impact of disasters.[12] Examples of mitigation efforts include elevating or relocating buildings from flood hazard areas, retrofitting buildings to make them more resistant to earthquakes or strong winds,

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[2] At the request of a disaster impacted state's Governor, the President may declare that a major disaster or emergency exists, thus activating an array of Federal programs to assist in the response and recovery effort. Not all programs, however, are activated for every disaster.

[3] Federal Emergency Management Agency. *Disaster Declarations by State/Tribal Government*. Available at: http://www.fema.gov/disasters/grid/state-tribal-government (Last viewed March 28, 2014).

[4] The NFIP is administered by the Federal Emergency Management Agency and provides property owners located in flood-prone areas the ability to purchase flood insurance protection from the federal government.

[5] Presentation to the Florida House of Representatives Insurance & Banking Subcommittee, by Lynne McChristian, Insurance Information Institute: "State of the Florida Property Insurance Market: Past, Present and Future," Feb. 19, 2014. p. 21. (Citing 2013 National Association of Insurance Commissioners). Available at http://www.iii.org/assets/docs/pdf/Florida-021914.pdf (Last viewed March 28, 2014).

[6] Storm surge is a complex phenomenon that occurs when water is pushed toward the shore through force of powerful winds associated with cyclonic storms. Storm surge has the potential to cause tremendous property loss, resulting in billions of dollars in property damage. *See infra* note 10, at 5 and 10.

[7] Core Logic. *2013 Storm Surge Report*. p. 13. Available at: http://www.corelogic.com/about-us/researchtrends/storm-surge-report.aspx (Last viewed March 28, 2014).

[8] Gulf region states, sometime referred to as "hurricane alley," include: Florida, Alabama, Mississippi, Louisiana, and Texas.

[9] *See supra* note 8, at 45.

[10] *See supra* note 8, at 44.

[11] Id.

[12] Federal Emergency Management Agency. *Mitigation's Value to Society Fact Sheet*. Available at: http://www.fema.gov/media-library-data/20130726-1621-20490-9581/mitigationvaluetosociety_2012.pdf (Last viewed March 28, 2014).

and adopting and enforcing adequate building codes set by local, state and federal governments.[13]

The Federal Emergency Management Agency (FEMA) manages various grant programs that encourage individuals and communities to take proactive steps to mitigate losses and damage. A 2005 study found that on average, a dollar spent by FEMA on hazard mitigation provides $4 in future benefits.[14]

In Florida, the state's Division of Emergency Management assists communities with mitigation efforts through the Residential Construction Mitigation Program.[15] The Program receives $7 million annually from the Florida Hurricane Catastrophe Trust Fund, of which:

- $2.8 million is designated for the Mobile Home Tie-Down Program. Based on legislative directive, the Division of Emergency Management provides the funding directly to Tallahassee Community College (TCC). By statute, TCC prepares a separate report for the Governor and the Legislature on these directives.
- $700,000 is designated for Hurricane Research to be conducted by Florida International University (FIU) to continue innovative research involving full-scale structural testing to determine inherent weakness of structures when subjected to categories 1 to 5 hurricane-force winds and rain, leading to new technologies, designs and products.
- Up to $3.4 million is to be used to improve the wind resistance of residences through loans, subsidies, grants, demonstration projects, direct assistance, and cooperative programs with local and federal governments. The program is developed in coordination with the Advisory Council whose members consist of representatives from the Florida Association of Counties, the Florida Department of Insurance, the Federation of Manufactured Home Owners, the Florida Manufactured Housing Association, the Florida Insurance Council, and the Florida Home Builders Association.

The Disaster Savings Account Act of 2014

The Disaster Savings Account Act of 2014, if enacted, will allow for up to $5,000 to be deducted from a taxpayer's yearly gross income and placed into a disaster saving account.[16] Homeowners would be allowed to spend funds from their account on approved mitigation, such as:

- Safe rooms;[17]
- Opening protection (i.e., impact and wind resistant windows, exterior doors, garage doors);
- Reinforcement of roof-to-wall and floor-to-wall connections for wind or seismic activity;
- Roof covering for impact, fire, or high wind resistance;

[13] Federal Emergency Management Agency. *The Disaster Process & Disaster Aid Programs.* Available at: http://www.fema.gov/disaster-process-disaster-aid-programs (Last viewed March 28, 2014).
[14] Multihazard Mitigation Council. *Natural Hazard Mitigation Saves: An Independent Study to Assess the Future Savings from Mitigation Activities*. 2005. Available at: http://c.ymcdn.com/sites/www.nibs.org/resource/resmgr/MMC/hms_vol1.pdf (Last viewed March 28, 2014).
[15] http://www.floridadisaster.org/mitigation/RCMP/index.htm (Last viewed March 28, 2014)
[16] Other congressionally approved tax-advantaged savings account include Individual Retirement Accounts (IRAs) and Health Savings Accounts (HSAs).
[17] A safe room is a hardened structure specifically designed to provide "near-absolute protection" in extreme weather events, including tornadoes and hurricanes.

- Cripple and shear walls to resist seismic activity;[18]
- Flood resistant building materials;
- Elevating structures and utilities above base flood elevation;
- Lightning protection systems;
- Whole home standby generators; and
- Any activity specified by the Secretary of the Treasury as appropriate to mitigate the risks of future hazards; or
- For the recovery of at least $3,000 in uninsured losses and expenses that were incurred during a state or federally declared disaster.

III. Effect of Proposed Changes:

The memorial urges Congress to pass the Disaster Savings Account Act of 2014. The Act would allow homeowners the ability to establish a tax-free savings account. The funds from the account are to be used for the costs of mitigation expenses intended to improve a home's resistance to storm damage.

If passed, copies of CS/SM 1298 are to be dispatched to the President of the United States, to the President of the United States Senate, to the Speaker of the United States House of Representatives, and to each member of the Florida delegation to the United States Congress.

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.

[18] Cripple walls are short exterior walls built on top of foundation walls to create a crawlspace. These walls are built to carry the entire weight of the house. During an earthquake, cripple walls must sustain lateral (horizontal) movement and are at risk of failure. This can cause the house to collapse or shift significantly, often off its foundation. Cripple walls were a common construction practice in west coast homes until 1950.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

None.

IX. Additional Information:

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

CS by Military and Veterans Affairs, Space, and Domestic Security on March 19, 2014:
The committee substitute elaborates on the unique risk of hurricanes and floods to Florida and the benefits of hazard mitigation to society.

B. Amendments:

None.

By the Committee on Military and Veterans Affairs, Space, and Domestic Security; and Senator Brandes

583-02831-14 20141298c1

A bill to be entitled

A memorial to the Congress of the United States, urging Congress to pass the Disaster Savings Accounts Act to encourage the mitigation of property damage and costs before a natural disaster strikes.

WHEREAS, Florida carries more hurricane risk than all of its neighboring "hurricane alley" states combined, and

WHEREAS, Florida, which represented less than 6 percent of the national population in 2011, accounts for about 40 percent of the total number of policies issued by the National Flood Insurance Program, and

WHEREAS, Florida, with its unique hurricane and flood risks, ranks among the most expensive in the nation for homeowners insurance, and

WHEREAS, mitigation programs and improvements produce safer structures and reduce the impact of natural disasters, thereby reducing property damage, loss of life, insurance rates, and other costs associated with disasters, and

WHEREAS, research shows that every dollar invested in mitigation results in 4 to 7 times that amount in savings, and

WHEREAS, disaster mitigation projects produce jobs in the manufacturing and construction sectors, and

WHEREAS, tax-preferred savings accounts encourage homeowners to fortify their homes, mitigate against future natural disasters, and invest in their own safety, and

WHEREAS, the Disaster Savings Accounts Act of 2014, proposed in H.R. 3989 and S. 1991, is a market-based solution to empower homeowners against natural disaster risks, and

583-02831-14 20141298c1

WHEREAS, the Disaster Savings Accounts Act of 2014 was introduced to amend the Internal Revenue Code of 1986 and to allow individuals a deduction for amounts contributed to disaster savings accounts to help defray the cost of preparing their homes to better withstand a disaster, NOW, THEREFORE,

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

That the Congress of the United States is urged to pass the Disaster Savings Accounts (DSA) Act of 2014, sponsored by United State Representative Dennis Ross and United States Senator Jim Inhofe, which allows individuals a deduction for amounts that are contributed to disaster savings accounts and used for disaster mitigation expenses.

BE IT FURTHER RESOLVED that copies of this memorial be dispatched to the President of the United States, to the President of the United States Senate, to the Speaker of the United States House of Representatives, and to each member of the Florida delegation to the United States Congress.

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/1/2014
Meeting Date

Topic DISASTER SAVINGS ACCT MEMORIAL

Bill Number SM 1298 *(if applicable)*

Name CHRISTIAN CAMARA

Amendment Barcode *(if applicable)*

Job Title STATE DIRECTOR

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Speaking: ☐ For ☐ Against ☒ Information

Representing R-STREET INST

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/1/14
Meeting Date

Topic Workers' Compensation — Bill Number SB 1298 *(if applicable)*

Name Disaster Savings Accounts — Amendment Barcode _____ *(if applicable)*

Job Title Policy Director

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Speaking: ☑ For ☐ Against ☐ Information

Representing FL Chamber of Commerce

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

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

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

S-001 (10/20/11)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1354
INTRODUCER:	Senator Grimsley
SUBJECT:	Health Care
DATE:	March 31, 2014
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.	Johnson	Knudson	BI	**Pre-meeting**

I. Summary:

SB 1354 revises the managed care accountability contract provisions for the statewide Managed Medical Assistance (MMA) contracts under the Statewide Medicaid Managed Care Program (SMMC). It requires plans that establish prescribed drug formularies to offer a range of therapeutic options with at least two products in each therapeutic class. Managed care plans under MMA must also cover any drugs newly approved by the United States Food and Drug Administration (FDA) until the Medicaid Pharmaceutical and Therapeutics Committee can review the drug for inclusion in the formulary. If a drug on a Medicaid managed care plan's formulary is removed or changed, the plan must allow an enrollee to continue that drug if the provider submits a written request that demonstrates the drug is medically necessary and the enrollee meets clinical criteria to receive the drug.

The bill requires MMA managed care plans, health insurers, managed care organizations, and health maintenance organizations and any pharmacy benefit manager under contract with these insurers, to use a standardized prior authorization form adopted by the Financial Services Commission (commission). The form is to be adopted by January 15, 2015. All prior authorization requests for medical procedures, course of treatment, and prescriptions must be submitted using the same standardized two-page form. A form submitted by a provider is deemed approved unless the issuer responds otherwise within two business days.

Managed care plans, health maintenance organizations and insurers, including Medicaid plans, that restrict medications by a step-therapy or fail-first protocol are required to have a clear and convenient process to request an override of the protocol. An override must be granted within 24 hours for certain situations where the prescribing provider believes the drug under the step-therapy or fail-first protocol has been or likely will be ineffective or will cause or will likely cause an adverse reaction. If the provider allows the patient to enter the step-therapy or fail-first protocol, the duration of the process may not exceed an amount deemed appropriate by the provider and if the provider deems it ineffective, the patient is entitled to receive the recommended course of treatment without override approval.

For insurance contracts for reduced rates of payment under s. 627.6471, F.S., the bill requires insurers to post a link on their website's homepage to a list of preferred providers. Changes to that list must be updated within 24 hours.

The bill has an indeterminate, but likely significant, fiscal impact.

II. Present Situation:

Medicaid

Medicaid is a joint federal and state funded program that provides healthcare for low income Floridians. The program is administered by the Agency for Healthcare Administration (AHCA). Over 3.3 million Floridians are currently enrolled in Medicaid and the program's estimated expenditures for Fiscal Year 2012-2013 were approximately $21 billion.[1] The statutory authority for the Medicaid program is contained in ch. 409, F.S.

Statewide Medicaid Managed Care

In 2011, the Legislature passed HB 7107[2] creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. The SMMC program requires the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits for the delivery of primary and acute care under the Managed Medical Assistance component (MMA).[3] Final approval by the federal government of the 1915(b) Medicaid waiver for the MMA component of SMMC program was received on June 14, 2013.[4] The AHCA recently begun the waiver renewal process for the period of July 1, 2014, through June 30, 2017.[5]

The AHCA is in the process of implementing the MMA component of SMMC program through which most Medicaid recipients will receive their health care services. The first regional roll-out begins May 1, 2014, and the last is scheduled for August 1, 2014. During the implementation, existing Medicaid managed care plans will continue until the region they serve transitions to the MMA program.

The AHCA's contracts with the current Medicaid managed care plans allow the plans to develop their own preferred drug list (PDL) and prior authorization processes, including step-therapy and fail-first criteria, which must be approved by the AHCA.[6] Current managed care plans also have

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[1] Agency for Health Care Administration, *Florida Medicaid*, http://ahca.myflorida.com/Medicaid/index.shtml (last visited Nov. 26, 2013).
[2] *See* ch. 2011-134, L.O.F.
[3] Health and Human Services Committee, Fla. House of Representatives, *PCS HHSC 11-01 Staff Analysis*, p.25, (Mar. 25, 2011).
[4] *See* Correspondence between Agency for Health Care Administration and the Centers for Medicare and Medicaid Services, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/06-14-2013_Appproval_Letter.pdf (last visited Nov. 21, 2013).
[5] Agency for Health Care Administration, *Managed Medical Assistance - Federal Authorities*, http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#FCA (last visited Nov. 21, 2013).
[6] Agency for Health Care Administration, *2014 Agency Bill Analysis - SB 1354* (Feb. 21, 2014), p. 2, on file with the Senate Health Policy Committee.

the ability to deny claims for enrollees who were later determined to be ineligible at the time of service despite having issued a prior authorization.[7]

For the first year of the MMA transition, the AHCA is requiring the MMA plans to use the Medicaid PDL. After the first year, the MMA plans may develop a plan-specific PDL for the Agency's consideration, if requested by the Agency at that time.[8]

Patient Protection and Affordable Care Act

In March 2010, the Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).[9] Among its changes to the United States health care system are requirements for health insurers to make coverage available to all individuals and employers. Qualifying coverage may be obtained through an employer, the federal or state exchanges created under PPACA, or private individual or group coverage meeting the minimum essential benefits coverage standard. Florida did not establish its own state exchange under PPACA.

Premium credits and other cost sharing subsidies are available to United States citizens and legal immigrants within certain income limits for qualified coverage purchased through the exchange. Premium credits are set on a sliding scale based on a percentage of the federal poverty level and reduce the out of pocket costs incurred by individuals and families.[10]

Federal regulations for PPACA also govern an enrollee's coverage bought through the exchanges and for non-grandfathered plans.[11] If an enrollee's coverage bought with advance premium tax credit for a qualified health plan (QHP)[12] is terminated for non-payment of premium, for example, the regulations provide the enrollee a 3-month grace period before cancellation of coverage.[13] During the grace period, the insurer must pay claims for services rendered in the first month but may pend claims for the second and third months.[14] If coverage is ultimately terminated, the termination date is the last day of the first month of the grace period and the insurer may not recoup any claims paid during the first month of the grace period.

The federal regulations do not affect those enrollees who are not enrolled in an exchange plan or are not receiving a subsidy. The grace period for these individuals remains at the length required under s. 627.608, F.S., which varies by the length of the premium payment interval. Cancellation of coverage is effective the first day of the grace period if payment is not received.

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[7] *Id.*
[8] *Id.*
[9] P.L. 111-148. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.
[10] Centers for Medicare and Medicaid Services, *Health Insurance Marketplace - Will I Qualify for Lower Costs on Monthly Premiums?* https://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/ (last visited Mar. 22, 2014).
[11] Certain plans received "grandfather status" under PPACA. A grandfathered health plan is a plan that existed on March 23, 2010, and had at least one person continuously covered for one year. Some consumer protections elements do not apply to grandfathered plans.
[12] A "qualified health plan" is an insurance plan certified by the applicable Health Insurance Marketplace, provides the essential health benefits, established limits on cost sharing and meets other requirements. *See* https://www.healthcare.gov/glossary/qualified-health-plan/ for more information on qualified health plans.
[13] 45 CFR 156.270 and 45 CFR 430.
[14] 45 CFR 156.270.

Step-Therapy or Fail-First Protocols

Step-therapy or fail-first protocols for prescription medication coverage require a member to try a certain drug, usually a generic alternative, before receiving coverage for another drug, usually a branded, more expensive product. Utilization management pharmacy benefit programs were first introduced in the 1980s and became popular with the implementation of tiered co-payment formularies.[15] Step therapy is usually applied to a certain drug class with the goal of encouraging generic drug use and decreasing costs without compromising the quality of care.[16] Many step-therapy programs incorporate edits into the system to recognize members through prior claims who have previously received a first step drug so claims for a second step drug are not rejected, but automatically covered.

One outcome of step-therapy programs; however, has been that enrollees who have had a claim rejected do not have a later claim for a later medication in that same class.[17] The process for notifying the patient and prescriber of a step-therapy claim rejection and the resubmission of an alternate medication varies by insurer.

Prior Authorization for Health Care Services

Insurers may require prior authorization for certain services as a cost control and quality measure. Florida has waived requirements for prior authorization for certain services and requires direct access within specified guidelines for certain services such as dermatology.[18] State law currently does not provide a specific standard form or review timeline for a prior authorization process for health care services covered by an insurer, managed care plan or health maintenance organization. Prior authorization is never required for any emergency procedure. Each insurer has established its own prior authorization process and form based on the situation and the type of authorization, such service, course of treatment, or prescription. The state has mandated a standard health claims processing form be adopted by the commission and used under s. 627.647, F.S., by all hospitals and a separate form by all physicians, dentists and pharmacists.

The National Council for Prescription Drug Programs, a non-profit, stakeholder group, proposed new uniform electronic prior authorization (ePA) standards in July 2013. The new ePA electronic prescribing standard provides for a two-way, real-time exchange of information for insurers and prescribers.[19]

Federal regulations for the Medicaid and Children's Health Insurance Program both require that managed care plans have written policies and procedures for initial and continuing authorization decisions that ensure timely access to care for enrollees with serious and chronic conditions.[20]

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[15] Patrick P. Gleason, PharmD, FCCP, BCPS, *Assessing Step-Therapy Programs: A Step in the Right Direction*, www.amcp.org, Journal of Managed Care Pharmacy, p. 274, http://www.amcp.org/data/jmcp/273-75.pdf (April 2007, Vol. 13, No. 3) (last visited Mar. 23, 2014).
[16] *Id*.
[17] Gleason, *supra*, note 15 at 273-274.
[18] *See* s. 641.31(33), F.S. Provides direct access to dermatologists for up to 5 visits and testing annually.
[19] Press Release, National Council for Prescription Drug Programs, *New Uniform Electronic Prior Authorization Standard Supplants the Need for Legislation (*March 6, 2014) on file in the Senate Health Policy Committee.
[20] *See* 42 CFR 438.210 (Medicaid) and 42 CFR 495 (Children's Health Insurance Program).

Both regulations establish that prior authorization decisions may not exceed 14 calendar days following receipt of the request, with a possible extension up to 14 additional calendar days if requested by the enrollee or provider or there is a need for additional information.

For Medicaid, an expedited authorization process is also provided that does not exceed 3 working days with the ability to extend up to 14 calendar days upon enrollee request, or if the managed care plan justifies a need for additional information and that the extension is in the enrollee's benefit.[21] Regulations governing the Children's Health Insurance Program provide a deferral to any existing state law on the authorization of health services, if applicable.[22]

Preferred Provider Listings

Individuals enrolled in plans licensed under s. 627.6471, F.S., known as a "Preferred Provider Organization" or PPO plans, incur higher out of pocket costs if the provider is out of network. These out of pocket costs can be significant to the consumer. For example, in the standard PPO Option Group Plan for state employees, the enrollee would pay a small copayment for a physician office visit with an in-network provider after the enrollee had met any calendar year deductible, but would incur 40 percent of the costs with an out of network provider for the same service.[23] The state group PPO provider, Florida Blue, provides a list of providers on its website.

Federal regulations require QHPs on the exchanges to make its provider directory available online and to potential enrollees in hard copy, upon request.[24] Further guidance from the federal Centers for Medicare and Medicaid Services (CMS) via a draft guidance letter indicates that QHPs must provide a link from the federal marketplace to their network directly where the consumer can view an up-to-date provider directory. CMS requires the directory to include the location, contact information, specialty, medical group, any institutional affiliations for each provider and whether the provider is accepting new patients.[25]

III. Effect of Proposed Changes:

Medicaid Managed Care Program (Section 1)

Section 1 revises s. 409.967, F.S., and requires a Medicaid managed care plan that establishes a prescribed drug formulary or a PDL must provide a broad range of therapeutic options for the treatment of disease consistent with the outpatient population. At least two products in each therapeutic class must be included, if feasible. The AHCA indicates it will be required to amend its existing Medicaid contracts to ensure compliance.[26]

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[21] 42 CFR 438.210.
[22] 42 CFR 457.495(d)(2).
[23] Florida Blue, 2014 Benefits, State Employees' PPO Plan, on file with the Senate Health Policy Committee.
[24] 45 CFR 156.235(b).
[25] Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, *Draft 2015 Letter to Issuers in the Federally-Facilitated Marketplace* (Feb. 4, 2014), pg. 47, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf (last visited Mar. 23, 2014).
[26] *See supra,* note 6.

The managed care plan must also provide coverage through prior authorization for any new drug approved by the Food and Drug Administration until the Medicaid Pharmaceutical and Therapeutics Committee (committee) can review the drug for inclusion on the formulary. The timing of the committee meeting must comply with s. 409.91195, F.S., which requires at least quarterly meetings.

If a managed care plan removes a drug from a plan's formulary, the bill requires the managed care plan to continue the enrollee's receipt of the drug if the provider submits a written request that the drug is medically necessary and meets clinical criteria.

Prior Authorization Requirements (Sections 1, 3, and 7)

Health plans, health insurers, and health maintenance organizations, including those participating under SMMC, will be required, upon adoption by the commission after January 1, 2015, to use a new, standardized prior authorization form for obtaining approval for a medical procedure, course of treatment, or prescription drug benefit. A pharmacy benefit manager under contract with a managed care plan must also comply with this requirement. The form must be available electronically from the commission and on the managed care plan's website. A prior authorization request completed on the standardized form will be deemed approved upon receipt by the managed care plan unless the managed care plan responds within two business days.

SB 1354 adds the prior authorization provisions to existing s. 409.967, F.S., and creates two new sections, ss. 627.6465 and 641.393, F.S.

Step-Therapies or Fail-First Protocols (Sections 1, 4, and 8)

If medications for the treatment of a medical condition are restricted for use through a step-therapy or fail-first protocol by a SMMC plan, an insurer, or a health maintenance organization, the prescribing provider must have access to a clear and convenient process to request an override. An override must be granted within 24 hours if the prescribing provider believes that:

- Based on sound clinical evidence, the preferred treatment required under step-therapy or fail-first protocol has been ineffective in the patient's disease or medical condition; or
- Based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:
    - Is expected or likely to be ineffective based on known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen; or
    - Will cause or will likely cause an adverse reaction or other physical harm to the patient.

If the patient does enroll in the step-therapy or fail-first protocol, the duration of the process may not exceed a period deemed appropriate by the provider. If the provider finds the treatment ineffective, the bill provides that the patient is entitled to receive the recommended course of treatment without requiring the provider to seek an override of the step-therapy or fail-first protocol.

To add the provisions on step-therapy and fail-first protocol for the SMMC program, s. 409.967, F.S., is amended and two new sections, ss. 627.6466 and 641.394, F.S., are created to apply the provisions to insurers and health maintenance organizations.

Payment of Claims (Sections 2 and 6)

Health insurers under s. 627.6131, F.S., and health maintenance organizations under s. 641.3155, F.S., are prohibited from retroactively denying claims because of insured ineligibility if the insurer:

- Verified the eligibility of the insured at time of treatment and provided an authorization number; or
- Provided the insured with an identification card as provided in s. 627.642(3), F.S., which at the time of service identifies the insured as eligible to receive services.

Reduced Rate Insurance Contracts - Provider Listings (Section 5)

For contracts for reduced rates of payment, s. 627.6471, F.S., is revised and insurers must post a link on their website's homepage to a list of preferred providers. Changes to the provider list must be updated within 24 hours.

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

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:

Individuals and employers with private insurance coverage may see an increase in premium costs related to the step-therapy or fail-first process and the prior authorization provisions. These measures are used by insurers today as utilization management and cost control tools and might impact some current policies and procedures of insurers.

Consumers may see more timely authorization for certain services, course of treatment, or prescriptions ordered by their health care providers. Health care providers and their patients may also experience less of a burden receiving a brand drug under the step-therapy or fail-first guidelines because patients are provided a statutory mechanism for bypassing step one, if certain indicators are present.

Insurers under s. 627.6471, F.S., have an additional administrative impact complying with posting a list of preferred providers to their website and reflecting changes within 24 hours.

C. Government Sector Impact:

The fiscal impact to Medicaid is indeterminate at this time. The bill may increase the cost of providing a prescribed drug to Medicaid enrollees because it makes changes to the step-therapy and fail-first requirements for plan enrollees and requires that any drug prescribed or recommended by a provider be approved and reimbursed.

The AHCA would also need to modify existing Medicaid managed care contracts to incorporate the revised step-therapy and formulary requirements.

This bill would have a negative, significant, indeterminate impact on the State Employees' Health Insurance Trust Fund. The Division of State Group Insurance of the Department of Management Services provided the following comments regarding the impact of the bill:[27]

Step-therapy (Fail-first Protocols): Although quantity limits are required for certain medications, the State Employees Prescription Drug Plan covers all federal legend drugs except as excluded in the Plan document. Step-therapy (fail-first protocols) and prior authorization for PPO Plan members are prohibited pursuant to footnote 1 of s. 110.12315, F.S. Although step-therapy is not prohibited for the HMO plans, it is not currently used.

Retroactive Termination of Coverage: SB 1354 would require the State Employees' PPO Plan and HMO plans to pay medical and prescription drug claims for patients whose insurance coverage has been terminated retroactively (as allowed under PPACA). Prohibiting federally allowable retro-denial of claims because of ineligibility could result in the health plan paying for services and could significantly increase the cost of health care coverage for the plan.

Prior Authorization Forms: The bill's requirement for health plans and pharmacy benefit plans to use a standardized authorization form when requesting a health plan's prior approval of a service or prescription could impede and decrease efficiency for the prior authorization process for both the doctor and the health plan. For example, the two-page form submitted may be incomplete or not have the necessary information to make an informed decision within two business days. It is unclear if there is a mechanism to

[27] Department of Management Services, SB 1354 Analysis (Mar. 25, 2014) on file with Senate Committee on Banking and Insurance).

request additional information to make a decision outside of the two-day window, nor does there appear to be a process for unfavorable decisions or for cases needing same-day decisions (e.g., emergency situations). The two-day turnaround is shorter than timelines set by the National Committee on Quality Assurance (NCQA).

Further, drugs and services subject to prior authorization vary greatly among health plans; it would not be possible to design a single prior authorization form that meets every medical and/or prescription drug need or use. The rules for this form are not required to be completed until at least January 1, 2015, but this is the same day the insurance companies, HMOs, and PBMs must start using the form.

Member Identification Cards: As written, this bill appears to allow anyone holding a member ID card from a health plan to have health insurance coverage. The member ID card is intended to be a convenience for both participants and medical providers, not the final determination of eligibility. For plans that only use the policyholder's name on the card, the potential to share the card with other, noncovered persons could exist. Legitimately terminated participants could use the card to gain access to services. If enacted, this bill would require the plan to pay for services for ineligible persons, with the potential to greatly increase plan costs.

Online Provider Directory: Regarding the 24-hour timeframe, the bill does not address situations where the provider may end its network status retroactively.

VI. Technical Deficiencies:

On lines 299, 305, and 308 the term, "insured's" or "insured" are used. For purposes of ch. 641, F.S., relating to health maintenance organization, the term subscriber(s) or member(s) is used.

Section 5 of the bill requires insurers to update changes in the list of preferred providers on their website within 24 hours. It is unclear whether the online list will need to be updated within 24 hours of any change in contracts with preferred providers, or may be updated by the end of the next day.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967, 627.6131, 627.6471, and 641.3155.

This bill creates the following sections of the Florida Statutes: 627.6465, 627.6466, 641.393, and 641.394.

IX. Additional Information:

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

None.

B. Amendments:

None.

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment

Delete lines 159 - 167
and insert:
(b) A health insurer that has verified the eligibility of an insured at the time of treatment and has provided an authorization number may not retroactively deny a claim because of insured ineligibility under a federal Patient Protection and Affordable Care Act compliant policy unless at the time eligibility was verified by the insurer, the provider was

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notified that the insured was delinquent in paying the premium.

383102

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment

Delete lines 253 - 261
and insert:
(b) A health maintenance organization that has verified the eligibility of a subscriber at the time of treatment and has provided an authorization number may not retroactively deny a claim because of subscriber ineligibility under a federal Patient Protection and Affordable Care Act compliant contract unless at the time eligibility was verified by the health

383102

maintenance organization the provider was notified that the subscriber was delinquent in paying the premium.

By Senator Grimsley

21-01230-14 20141354__

A bill to be entitled

An act relating to health care; amending s. 409.967, F.S.; revising contract requirements for managed care programs; providing requirements for plans establishing a drug formulary or list; requiring the use of a standardized form; establishing a process for providers to override certain treatment restrictions; amending s. 627.6131, F.S.; prohibiting retroactive denial of claims in certain circumstances; creating s. 627.6465, F.S.; requiring the use of a standardized form; requiring the commission to adopt rules to prescribe the form; providing requirements for the form; providing requirements for the availability and submission of the form; creating s. 627.6466, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override process in certain circumstances; amending s. 627.6471, F.S.; requiring insurers to post preferred provider information on a website; amending s. 641.3155, F.S.; prohibiting retroactive denial of claims in certain circumstances; creating s. 641.393, F.S.; requiring the use of a standardized form; providing requirements for the availability and submission of the form; creating s. 641.394, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override process in certain circumstances;

21-01230-14 20141354__

providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

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

(c) *Access.*—

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

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

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

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

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

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

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

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

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

3.a. Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, after January 1, 2015, a managed care plan shall use only the standardized prior authorization form adopted by the Financial Services Commission pursuant to s. 627.6465 for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefits. If a managed care plan contracts with a pharmacy benefits manager to perform prior authorization services for prescription drug benefits, the pharmacy benefits manager shall use and accept the standardized prior authorization form. The form shall be made available electronically by the commission and on the managed care plan's website. The prescribing provider may submit the completed form electronically to the managed care plan.

b. A completed prior authorization request submitted by a

health care provider using the standardized prior authorization form required under sub-subparagraph a. is deemed approved upon receipt by the managed care plan unless the managed care plan responds within 2 business days.

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

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

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

b. The prescribing provider believes that, based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

(I) Is expected or likely to be ineffective based on known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen; or

(II) Will cause or will likely cause an adverse reaction or other physical harm to the enrollee.

If the prescribing provider allows the enrollee to enter the step-therapy or fail-first protocol recommended by the managed

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

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

627.6131 Payment of claims.—

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

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

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

Section 3. Section 627.6465, Florida Statutes, is created to read:

627.6465 Prior authorization.—

(1) Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, after January 1, 2015, a health insurance issuer, managed care plan as defined in s. 409.901, or health maintenance organization as

defined in s. 641.19 shall use only the standardized prior authorization form adopted by the Financial Services Commission for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefits. If a health insurance issuer, managed care plan, or health maintenance organization contracts with a pharmacy benefits manager to perform prior authorization services for prescription drug benefits, the pharmacy benefits manager shall use and accept the standardized prior authorization form. The commission shall adopt rules prescribing the prior authorization form on or before January 1, 2015, and may consult with health insurance issuers or other organizations as necessary in the development of the form. The form may not exceed two pages in length, excluding any instructions or guiding documentation. The form shall be made available electronically by the commission and on the website of the health insurance issuer, managed care plan, or health maintenance organization. The prescribing provider may submit the completed form electronically to the health benefit plan. The adoption of the form by the commission does not constitute a determination that affects the substantial interests of a party under chapter 120.

(2) A completed prior authorization request submitted by a prescribing provider using the standardized prior authorization form required under subsection (1) is deemed approved upon receipt by the health insurance issuer unless the health insurance issuer responds within 2 business days.

Section 4. Section 627.6466, Florida Statutes, is created to read:

627.6466 Fail-first protocols.—If medications for the

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

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

(2) The prescribing provider believes that, based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

(a) Is expected or likely to be ineffective based on known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

(b) Will cause or is likely to cause an adverse reaction or other physical harm to the insured.

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

Section 5. Subsection (2) of section 627.6471, Florida Statutes, is amended to read:

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

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

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

641.3155 Prompt payment of claims.—

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

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

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

Section 7. Section 641.393, Florida Statutes, is created to read:

641.393 Prior authorization.—

(1) Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, after January 1, 2015, a health maintenance organization shall use only the standardized prior authorization form adopted by the Financial Services Commission pursuant to s. 627.6465 for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefits. If a health maintenance organization contracts with a pharmacy benefits manager to perform prior authorization services for prescription drug benefits, the pharmacy benefits manager must use and accept the standardized prior authorization form. The form shall be made available electronically by the commission and on the website of the health insurance issuer, managed care plan, or health maintenance organization. The health care provider may submit the completed form electronically to the health benefit plan.

(2) A completed prior authorization request submitted by a health care provider using the standardized prior authorization form required under subsection (1) is deemed approved upon receipt by the health maintenance organization unless the health maintenance organization responds within 2 business days.

Section 8. Section 641.394, Florida Statutes, is created to read:

641.394 Fail-first protocols.—If medications for the treatment of a medical condition are restricted for use by a health maintenance organization by a step-therapy or fail-first

protocol, the prescribing provider shall have access to a clear and convenient process to request an override of the protocol from the health maintenance organization. The health maintenance organization shall grant an override of the protocol within 24 hours if:

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

(2) The prescribing provider believes that, based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

(a) Is expected or likely to be ineffective based on known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

(b) Will cause or is likely to cause an adverse reaction or other physical harm to the insured.

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

Section 9. This act shall take effect July 1, 2014.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1494
INTRODUCER:	Senator Thrasher
SUBJECT:	Civil Remedies Against Insurers
DATE:	March 31, 2014 REVISED:

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

I. Summary:

SB 1494 provides a 45 day window in which an insurer can act to avoid liability for failing to attempt to settle a claim in good faith. A third-party bad faith claim arises when an insurer fails in good faith to settle a third party's claim against the insured within policy limits and exposes the insured to liability in excess of his or her insurance coverage. A third-party claim can be brought by the insured, having been held liable for judgment in excess of policy limits by the third-party claimant.

This bill provides that before a third-party bad faith action for failure to settle a liability insurance claim may be filed, the claimant must provide the insurer a written notice of loss. To avoid bad faith liability for failing to attempt a settle a claim in good faith, the insurer must comply with a request for a disclosure statement and, within 45 days after receipt of the written notice of loss, offer to pay the claimant the lesser of the amount that the claimant is willing to accept in exchange for a full release of the insured from any liability arising from the incident reported in the written notice of loss or the limits of liability coverage applicable to the claimant's insurance claim. If the insurer complies with these conditions, the insurer does not violate the duty to attempt in good faith to settle the claim and is not liable for bad faith failure to settle.

This bill is effective July 1, 2014.

II. Present Situation:

Obligations of Insurer to Insured

An insurer generally owes two major contractual duties to its insured in exchange for premium payments—the duty to indemnify and the duty to defend. The duty to indemnify refers to the insurer's obligation to issue payment either to the insured or a beneficiary on a valid claim. The

duty to defend refers to the insurer's duty to provide a defense for the insured in court against a third party with respect to a claim within the scope of the insurance contract.[1] The Florida Supreme Court explained the difference between indemnity policies and liability policies:

> Under indemnity policies, the insured defended the claim and the insurance company simply paid a claim against the insured after the claim was concluded. Under liability policies, however, insurance companies took on the obligation of defending the insured, which, in turn, made insureds dependent on the acts of the insurers; insurers had the power to settle and foreclose an insured's exposure or to refuse to settle and leave the insured exposed to liability in excess of policy limits.[2]

Historically, damages in actions for breaches of insurance contracts were limited to those contemplated by the parties when they entered into the contract.[3] As liability policies began to replace indemnity policies as the standard insurance policy form, courts recognized that insurers owed a duty to act in good faith towards their insureds.[4]

Common Law and Statutory Bad Faith

Florida courts for many years have recognized an additional duty that does not arise directly from the insurance contract, the common law duty of good faith on the part of an insurer to the insured in negotiating settlements with third-party claimants.[5] The common law rule is that a third-party beneficiary who is not a formal party to a contract may sue for damages sustained as the result of the acts of one of the parties to the contract.[6] This is known as a third-party claim of bad faith.

At common law, the insured cannot raise a bad faith claim against the insurer outside of the third-party claim context.[7] In 1982, the Legislature enacted s. 624.155, F.S. Section 624.155, F.S., recognizes a claim for bad faith against an insurer not only in the instance of settlement negotiations with a third party but also for an insured seeking payment from his or her own insurance company. This is known as a first-party claim of bad faith.

Section 624.155, F.S., provides that any party may bring a bad faith civil action against an insurer, and defines bad faith on the part of the insurer as:

- Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured with due regard for her or his interests;
- Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

[1] *See* 16 Williston on Contracts s. 49:103 (4th Ed.).
[2] *See State Farm Mutual Automobile Insurance Company v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).
[3] *See State Farm Mutual Automobile Insurance Company v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).
[4] *Id*.
[5] *See Auto. Mut. Indem. Co. v. Shaw*, 184 So. 852 (Fla. 1938).
[6] *See Thompson v. Commercial Union Insurance Company*, 250 So.2d 259 (Fla. 1971).
[7] *See Laforet*, 658 So.2d at 58-59.

- Except as to liability coverages, failing to promptly settle claims, when the obligation to settle the claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.[8]

In order to bring a bad faith claim under the statute, a plaintiff must first give the insurer 60 days written notice of the alleged violation.[9] The insurer has 60 days after the required notice is filed to pay the damages or correct the circumstances giving rise to the violation.[10] Because first-party claims are only statutory, that cause of action does not exist until the 60-day cure period provided in the statute expires without payment by the insurer.[11] Third-party claims, on the other hand, exist both in statute and at common law, so the insurer cannot guarantee avoidance of a bad faith claim by curing within the statutory period.[12]

In interpreting what it means for an insurer to act fairly toward its insured, Florida courts have held that when the insured's liability is clear and an excess judgment is likely due to the extent of the resulting damage, the insurer has an affirmative duty to initiate settlement negotiations.[13] If a settlement is not reached, the insurer has the burden of showing that there was no realistic possibility of settlement within policy limits.[14] Failure to settle on its own, however, does not mean that an insurer acts in bad faith. Negligent failure to settle does not rise to the level of bad faith. Negligence may be considered by the jury because it is relevant to the question of bad faith but a cause of action based solely on negligence is not allowed.[15]

Third-Party Claims of Bad Faith

A third-party bad faith claim arises when an insurer fails in good faith to settle a third party's claim against the insured within policy limits and exposes the insured to liability in excess of his or her insurance coverage.[16] The Florida Supreme Court has described an insurer's duty to its insureds:

> An insurer, in handling the defense of claims against its insured, 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. For when the insured has surrendered to the insurer all control over the handling of the claim, including all decisions with regard to litigation and settlement, then the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured. This good faith duty obligates the insurer to advise the insured of settlement opportunities, to advise as to the probable

[8] *See* s. 624.155(1)(b)1.-3., F.S.
[9] *See* s. 624.155(3)(a), F.S. The notice must be on a form approved by the Department of Financial Services. If the Department returns the notice for lack of specificity, the day period does not begin until a proper notice is filed. The notice form can be found at https://apps.fldfs.com/CivilRemedy/ (last accessed on March 29, 2014).
[10] *See* s. 624.155(3)(d), F.S.
[11] *See Talat Emterprises vv. Aetna Casualty and Surety Company*, 753 So.2d 1278, 1284 (Fla. 2000).
[12] *See Macola v. Government Employees Insurance Company*, 953 So.2d 451 (Fla. 2006).
[13] *See Powell v. Prudential Property and Casualty Insurance Company*, 584 So.2d 12, 14 (Fla. 3d DCA 1991).
[14] *Id*.
[15] *See DeLaune v. Liberty Mutual Insurance Company*, 314 So.2d 601,603 (Fla. 4th DCA 1975).
[16] *See Opperman v. Nationwide Mutual. Fire Insurance Company,* 515 So.2d 263, 265 (Fla. 5th DCA 1987).

> outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid same. The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so. Because the duty of good faith involves diligence and care in the investigation and evaluation of the claim against the insured, negligence is relevant to the question of good faith. The question of failure to act in good faith with due regard for the interests of the insured is for the jury.[17]

In light of this heightened duty on the part of the insurer, Florida courts focus on the actions of the insurer, not the claimant.[18] Whether an insurer acted in bad faith is determined by the totality of the circumstances:

> In Florida, the question of whether an insurer has acted in bad faith in handling claims against the insured is determined under the totality of the circumstances standard. Each case is determined on its own facts and ordinarily the question of failure to act in good faith with due regard for the interests of the insured is for the jury.[19]

The focus in a bad faith case is on the conduct of the insurer but the conduct of the claimant is relevant to whether there was a realistic opportunity for settlement.[20] A court, for example, will look at the terms of a demand for settlement to determine if the insurer was given a reasonable amount of time to investigate the claim and make a decision whether settlement would be appropriate under the circumstances. One court held that dismissal of a bad faith claim was proper where the settlement demand in question gave a 10-day window, pointing out that "[i]n view of the short space of time between the accident and institution of suit, the provision of the offer to settle limiting acceptance to 10 days made it virtually impossible to make an intelligent acceptance."[21] Although in this particular circumstance the court found that 10 days was not enough, it is not clear exactly what time period or other conditions for acceptance would be permissible, because courts look at the facts on a case-by-case basis and the current statute is silent on this point.

In *Berges*, dissenting justices expressed concern that there "is a strategy which consists of setting artificial deadlines for claims payments and the withdrawal of settlement offers when the artificial deadline is not met."[22] It was argued that it is a "common practice for a party contemplating litigation to submit a settlement offer that remains outstanding for only a finite period and that a person injured by a policyholder may set any deadlines he desires—even an

[17] *Boston Old Colony Insurance Company v. Gutierrez*, 386 So.2d 783, 785 (Fla. 1980)(internal citations omitted).
[18] *See Berges v. Infinity Insurance Company*, 896 So.2d 665, 677 (Fla. 2005)(explaining that "the focus in a bad faith case is not on the actions of the claimant but rather on those of the insurer in fulfilling its obligations to the insured").
[19] *See Berges*, 896 So.2d at 680 (internal quotations and citations omitted).
[20] *See Barry v. GEICO General Insurance Company*, 938 So.2d 613, 618 (Fla. 4th DCA 2006).
[21] *DeLaune v. Liberty Mut. Ins. Co.*, 314 So.2d 601, 603 (Fla. 4th DCA 1975).
[22] *Berges*, 896 So.2d at 685 (Wells, J., dissenting).

arbitrary or unreasonable one."[23] Justice Wells concluded that set time periods in which all insurers must make decisions on claims and issue payments are needed.[24]

The majority in *Berges* held that courts must look to the totality of the circumstances. "The question of bad faith in this case extends to [the insurer's] entire conduct in the handling of the claim, including the acts or omissions [of the insurer] in failing to ensure payment of the policy limits within the time demands."[25] Another court argued that setting a "minimum amount of time before any finding of bad faith is possible runs counter to the analysis of ordinary care and prudent business practice… Juries are empaneled to apply the appropriate criteria to the particular facts of a given situation and to decide whether the insurer acted prudently."[26]

III. Effect of Proposed Changes:

This bill provides that, as a condition precedent to a third-party statutory or common-law bad faith action for failure to settle a liability insurance claim, the insured, the claimant, or anyone on behalf of the insured or the claimant must provide the insurer a written notice of loss. This bill does not change the requirements for first-party bad faith claims.

If the insurer complies with a request for a disclosure statement as described in s. 627.4137, F.S., and, within 45 days after receipt of the written notice of loss, offers to pay the claimant the lesser of the limits of liability coverage applicable to the claimant's insurance claim or the amount that the claimant is willing to accept in exchange for a full release of the insured from any liability arising from the incident reported in the written notice loss, the insurer does not violate the duty to attempt in good faith to settle the claim and is not liable for bad faith failure to settle.

Current law provides that bad faith is determined based on the totality of the circumstances. This bill would provide that an insurer is not liable for bad faith failure to settle if the insurer complies with the provisions of this bill.

This bill is effective July 1, 2014.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[23] *Id.* at 692 (Cantero, J., dissenting).
[24] *Id*. at 686 (Wells, J., dissenting).
[25] *Berges*, 896 So.2d at 627.
[26] *Snowden ex. rel. Estate of Snowden v. Lumbermans Mutual Casualty Company*, 358 F.Supp.2d 1125, 1129 (N.D. Fla. 2003).

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The private sector fiscal impact of this bill is indeterminate. This bill will create a 45 day window for insurers to avoid bad faith claims.

C. Government Sector Impact:

The government sector fiscal impact is indeterminate. This bill eliminates the requirement that claimants file a civil remedy notice in third-party bad faith cases.

VI. Technical Deficiencies:

On line 35, the term "notice loss" should be "notice of loss."

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 624.155 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Thrasher

6-01031-14 20141494__

A bill to be entitled

An act relating to civil remedies against insurers; amending s. 624.155, F.S.; requiring insureds and claimants, or persons acting on their behalf, to provide an insurer with written notice of loss as a condition precedent to bringing a statutory or common-law action for a third-party bad faith action for failure to settle an insurance claim; providing that an insurer is not liable for such claim if certain conditions are met; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 624.155, Florida Statutes, is amended, and subsection (10) is added to that section, to read:

624.155 Civil remedy.—

(3)(a) Except as provided in subsection (10), as a condition precedent to bringing an action under this section, the department and the authorized insurer must have been given 60 days' written notice of the violation. If the department returns a notice for lack of specificity, the 60-day time period does ~~shall~~ not begin until a proper notice is filed.

(10) As a condition precedent to a third-party statutory or common-law bad faith action for failure to settle a liability insurance claim, the insured, the claimant, or anyone on behalf of the insured or the claimant must have provided the insurer with a written notice of loss. If the insurer complies with a request for a disclosure statement as described in s. 627.4137

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and, within 45 days after receipt of the written notice of loss, offers to pay the claimant the lesser of the amount that the claimant is willing to accept or the limits of liability coverage applicable to the claimant's insurance claim in exchange for a full release of the insured from any liability arising from the incident reported in the written notice loss, the insurer does not violate the duty to attempt in good faith to settle the claim and is not liable for bad faith failure to settle under this section or the common law.

Section 2. This act shall take effect July 1, 2014.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1580
INTRODUCER:	Banking and Insurance Committee and Senator Hays
SUBJECT:	Workers' Compensation Cost Task Force
DATE:	April 3, 2014
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			HP	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1580 creates the Workers' Compensation Cost Task Force, which is composed of 18 members. The Chief Financial Officer or his or her designee will serve as chair of the task force. The purpose of the task force is to analyze workers' compensation costs. Specifically, the task force is required to:

- Review and analyze the recommendations of the Three-Member Panel 2013 Biennial Report in the context of reducing workers' compensation costs.
- Develop a report that includes its findings and recommendations to the Legislature regarding a new payment methodology for hospital inpatient and outpatient reimbursements in workers' compensation cases, which would reward efficiency, quality, and outcomes.
- Address other factors related to workers' compensation costs, including, but not limited to, the volume of inpatient and outpatient services, the number of accidents and workers' compensation claims, fraud, the cost per claim and treatment, and tort costs related to workers' compensation care.

The task force is required to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15, 2015.

The bill provides that the Department of Financial Services (DFS) will provide administrative and staff support services for the task force. Members of the task force are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S. The DFS estimates the total costs associated with the task force would be $38,320.98.

II. Present Situation:

Florida's Workers Compensation Law

Chapter 440, F.S., is Florida's workers' compensation law. The Division of Workers' Compensation within the Department of Financial Services (DFS) is responsible for administering ch. 440, F.S. Generally, employers/carriers are required to provide medical and indemnity benefits to a worker who is injured due to an accident arising out of and during the course of employment. For such compensable injuries, an employer/carrier is responsible for providing medical treatment, which includes, but is not limited to, medically necessary care and treatment. Section 440.13, F.S., provides that fees charged for remedial treatment, care, and attendance, except for independent medical examinations and consensus independent medical examinations, generally may not exceed the applicable fee schedules adopted by the three-member panel or authorized in this section.

The three-member panel (panel) consists of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members appointed by the Governor, subject to confirmation by the Senate, one member who is a representative of employers and another member who is a representative of employees. The panel determines statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. In addition to establishing reimbursement allowances, the panel is required to submit recommendations biennially to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

In 2013, the three-member panel report[1] included the following recommendations that have not been addressed by the Legislature:

- Remove the statutory mandate in s. 440.13(12)(a), F.S., that requires reimbursement for outpatient hospital services to be based on a percent of "usual and customary charges" and fix the reimbursement amounts to 120 percent or 140 percent of Medicare's payments under its Outpatient Prospective Payment System; or, in the alternative;
    - If a change in the methodology for hospital outpatient reimbursement services is not adopted, define "usual and customary charge" in a manner so that all stakeholders are aware of its intended meaning and when it is to be used in determining reimbursement for medically necessary treatment, care and attendance provided in an outpatient hospital setting.
- Remove the statutory mandate in s. 440.13(12)(a), F.S., that requires reimbursement for inpatient hospital services to be based on per diem and fix the reimbursement amounts to 120 percent or 140 percent of Medicare's payments under its Inpatient Prospective Payment System.[2]

[1] *See* The Three-Member Panel 2013 Biennial Report, available at: http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Reports/3MP_Report_2013.pdf. (last visited Mar. 30, 2014).

[2] The three other recommendations were addressed by the Legislature in 2013 (Chapter 2013-131, s.1, Laws of Fla., and Chapter 2013-141, s. 6, Laws of Fla.).

III. Effect of Proposed Changes:

The bill creates the Workers' Compensation Cost Task Force. The Department of Financial Services will provide administrative and staff support services relating to the functions of the task force. The bill requires the task force to organize by July 1, 2014. The bill provides that the task force shall be composed of the following 18 members:

- The Chief Financial Officer, or his or her designee, who shall serve as chair of the task force.
- Three members of the task force who shall be the president or chief executive officer, or his or her designee, of the Florida Chamber of Commerce, Associated Industries of Florida, and the Florida Hospital Association.
- The Secretary of the Department of Health, or his or her designee.
- One member of the three-member panel.
- One member that represents a critical access hospital, appointed by the Speaker of the House of Representatives.
- One member who represents a rural hospital, appointed by the President of the Senate.
- Five members appointed by the President of the Senate and five members appointed by the Speaker of the House of Representatives, which must each include:
  - A member of the Legislature;
  - An owner or representative of a hospital system that has over 2,000 beds and provides services to a significant number of workers' compensation claims;
  - An owner or representative of a business that employs more than 500 employees;
  - An owner or representative of a business that employs less than 25 employees; and
  - A representative from an insurer that provides workers' compensation insurance.

The purpose of the task force is to analyze workers' compensation costs. The task force will review and analyze the recommendations of the Three-Member Panel 2013 Biennial Report in the context of reducing workers' compensation costs. The task force is required to develop a report that includes its findings and legislative recommendations regarding a new payment methodology for hospital inpatient and outpatient reimbursements in workers' compensation cases, which will reward efficiency, quality, and outcomes. The task force must address other factors related to workers' compensation costs, including, but not limited to, the volume of inpatient and outpatient services, the number of accidents and workers' compensation claims, fraud, the cost per claim and treatment, and tort costs related to workers compensation care. The task force is required to submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15, 2015.

Members of the task force will serve without compensation. However, they are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S.

The bill repeals the task force June 30, 2015.

The bill takes effect upon becoming a law.

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:

The bill requires the Department of Financial Services to provide administrative and staff support services for the task force. Members of the task force would be entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S. The task force is required to organize by July 1, 2014, and submit a report by January 1, 2015. The DFS estimates the following costs of the task force, based on a similar task force:[3]

Item	Amount
Travel	$18,331.80
Court Reporter	12,828.26
Meeting Room	7,029.25
Florida Administrative Weekly Notice	131.67
Total Expenditures	$38,320.98

VI. Technical Deficiencies:

None.

[3] E-mail from L. MaFaddin, Director of Legislative Affairs, Department of Financial Services (April 2, 2014) (on file with Senate Committee on Banking and Insurance).

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 440.13 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on April 1, 2014:
The CS eliminates provisions which would have revised the workers' compensation reimbursement allowances for hospital care.

The CS creates the Workers' Compensation Cost Task Force, which is composed of 18 members. The Department of Financial Services will provide administrative and staff support services for the task force. The purpose of the task force is to analyze workers' compensation costs and to submit a report containing findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15, 2015.

B. Amendments:

None.

809718

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
04/01/2014	.	
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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. Subsection (17) is added to section 440.13, Florida Statutes, to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(17) WORKERS' COMPENSATION COST TASK FORCE.—

(a) The Workers' Compensation Cost Task Force is created.

809718

The Department of Financial Services shall provide administrative and staff support services relating to the functions of the task force. The task force shall organize by July 1, 2014. The task force shall be composed of the following 18 members:

1. The Chief Financial Officer, or his or her designee, who shall serve as chair of the task force.

2. Three members of the task force who shall be the president or chief executive officer, or his or her designee, of the Florida Chamber of Commerce, Associated Industries of Florida, and the Florida Hospital Association.

3. The Secretary of the Department of Health, or his or her designee.

4. One member of the three-member panel, created under subsection (12).

5. One member that represents a critical access hospital, appointed by the Speaker of the House of Representatives.

6. One member who represents a rural hospital, appointed by the President of the Senate.

7. Five members appointed by the President of the Senate and five members appointed by the Speaker of the House of Representatives which must each include:

a. A member of the Legislature;

b. An owner or representative of a hospital system that has over 2,000 beds and provides services to a significant number of workers' compensation claims;

c. An owner or representative of a business that employs more than 500 employees;

d. An owner or representative of a business that employs

809718

less than 25 employees; and

e. A representative from an insurance company that provides workers' compensation insurance.

(b) Members of the task force shall serve without compensation, but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

(c) The purpose of the task force is to analyze workers' compensation costs. The task force shall review and analyze the recommendations of the Three-Member Panel 2013 Biennial Report in the context of reducing workers' compensation costs. The task force shall develop a report that includes its findings and recommendations for legislative action regarding a new payment methodology for hospital inpatient and outpatient reimbursements in workers' compensation cases which will reward efficiency, quality, and outcomes. The task force must address other factors related to workers' compensation costs, including, but not limited to, the volume of inpatient and outpatient services, the number of accidents and workers compensation claims, fraud, the cost per claim and treatment, and tort costs related to workers compensation care. The task force shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15, 2015.

(d) This subsection shall be repealed June 30, 2015.

Section 2. 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:

809718

A bill to be entitled

An act relating to the Workers' Compensation Cost Task Force; amending s. 440.13, F.S.; creating the Workers' Compensation Cost Task Force; providing for membership; providing duties; requiring the task force to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by a specified date; providing an expiration date; providing an effective date.

920234

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
04/01/2014	.	
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	.	
	.	

The Committee on Banking and Insurance (Diaz de la Portilla) recommended the following:

Senate Amendment to Amendment (809718)

Delete lines 15 - 21
and insert:
24 members:
1. The Chief Financial Officer, or his or her designee, who shall serve as chair of the task force.
2. Nine members of the task force who shall be the president or chief executive officer, or his or her designee, of each of the following: the Florida Chamber of Commerce;

920234

Associated Industries of Florida; the Florida Hospital Association; the Florida Justice Association; Florida Workers' Advocates; the Workers' Compensation Section of The Florida Bar; the Florida AFL-CIO; the Florida Professional Firefighters; and the Florida Police Benevolent Association.

By Senator Hays

11-01488-14 20141580__

A bill to be entitled

An act relating to reimbursement allowances for hospital care; amending s. 440.13, F.S.; modifying reimbursement allowance rates; providing that the maximum reimbursement allowance for inpatient hospital care is a specified percentage of the rate allowed under the Medicare hospital inpatient prospective payment system; providing that compensable charges for hospital outpatient care is a specified percentage of the rate allowed under the Medicare hospital outpatient prospective payment system; providing an effective date.

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

Section 1. Subsection (12) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(a) A three-member panel is created, consisting of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a

11-01488-14 20141580__

representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be 140 percent of the rate allowed under the Medicare hospital inpatient prospective payment system ~~based on a schedule of per diem rates~~, to be approved by the three-member panel no later than October 1, 2015 ~~March 1, 1994~~, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which may ~~shall~~ not exceed 23 hours. All compensable charges for hospital outpatient care shall be reimbursed at 140 percent of the rate allowed under the Medicare hospital outpatient prospective payment system ~~75 percent of usual and customary charges, except as otherwise provided by this subsection~~. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, ~~hospital inpatient care, hospital outpatient care,~~ ambulatory surgical centers, work-hardening programs, and pain programs. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.

(b) It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions

developed pursuant to this subsection are limited to the following:

1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

2. Payments for scheduled outpatient nonemergency radiological and clinical laboratory services that are not provided in conjunction with a surgical procedure shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

3. Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges.

4. Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be increased to 110 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

5. Maximum reimbursement for surgical procedures shall be increased to 140 percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

(c) As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee. For repackaged or relabeled prescription medications dispensed by a dispensing practitioner as provided in s. 465.0276, the fee schedule for reimbursement shall be 112.5 percent of the average wholesale price, plus $8.00 for the dispensing fee. For purposes

of this subsection, the average wholesale price shall be calculated by multiplying the number of units dispensed times the per-unit average wholesale price set by the original manufacturer of the underlying drug dispensed by the practitioner, based upon the published manufacturer's average wholesale price published in the Medi-Span Master Drug Database as of the date of dispensing. All pharmaceutical claims submitted for repackaged or relabeled prescription medications must include the National Drug Code of the original manufacturer. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount except where the employer or carrier, or a service company, third party administrator, or any entity acting on behalf of the employer or carrier directly contracts with the provider seeking reimbursement for a lower amount.

(d) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, must not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical examinations performed by health care providers under this chapter. In determining the uniform schedule, the panel shall first approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening

program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the uniform schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers;

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.4001, and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers; and

4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.

(e) In addition to establishing the uniform schedule of maximum reimbursement allowances, the panel shall:

1. Take testimony, receive records, and collect data to evaluate the adequacy of the workers' compensation fee schedule,

nationally recognized fee schedules and alternative methods of reimbursement to health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey health care providers and health care facilities to determine the availability and accessibility of workers' compensation health care delivery systems for injured workers.

3. Survey carriers to determine the estimated impact on carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 1, 2003, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

(f) The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and any actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel. For prescription medication purchased under the requirements of this subsection, a dispensing practitioner shall not possess such medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing practitioner taking possession of that medication.

Section 2. This act shall take effect July 1, 2014.

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/1/14
Meeting Date

Topic Workers' Compensation — Bill Number SB 1580 *(if applicable)*

Name Carolyn Johnson — Amendment Barcode 809718 *(if applicable)*

Job Title Policy Director

Address 136 S Bronough St *Street* — Phone 850-521-1235

Tallahassee *City* FL *State* 32301 *Zip* — E-mail cjohnson@flchamber.com

Speaking: ☑ For ☐ Against ☐ Information

Representing FL Chamber of Commerce

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/1/14
Meeting Date

Topic Workers Comp

Bill Number 1580 *(if applicable)*

Name Gino Casanova

Amendment Barcode 809718 *(if applicable)*

Job Title Gov. Affairs

Address 14055 Riveredge Dr. Suite 250 *Street*

Phone 239-826-9863

Tampa *City* FL *State* 33637 *Zip*

E-mail giovanni.casanova@ahss.org

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Hospital

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/11
Meeting Date

Topic Work Comp

Bill Number 1580 *(if applicable)*

Name Bill Bell

Amendment Barcode _____ *(if applicable)*

Job Title General Counsel

Address 306 E College Ave
Street
Tall FL 32301
City *State* *Zip*

Phone 222-2800

E-mail bill@fha.org

Speaking: ☐ For ☑ Against ☐ Information

Representing FL Hospital Assn

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

4/1/14
Meeting Date

Topic WORKERS. COMP - HOSPITAL

Bill Number 1580 *(if applicable)*

Name PAUL M. ANDERSON

Amendment Barcode DLP *(if applicable)*

Job Title ATTORNEY

Address _____
Street

Phone 850-894-3000

1 ALLAHASSEE FL 32308
City *State* *Zip*

E-mail _____

Speaking: ☑ For ☐ Against ☐ Information

AMENDMENT BY SEN. DLP

Representing FLORIDA JUSTICE ASS.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/20/11)

CourtSmart Tag Report

Room: EL 110 **Case:** **Type:**
Caption: Senate Banking and Insurance Committee **Judge:**

Started: 4/1/2014 3:04:34 PM
Ends: 4/1/2014 3:56:54 PM Length: 00:52:21

3:04:40 PM Meeting called to order by Chair Simmons - Quorum present
3:06:17 PM Remarks by Chairmen
3:07:17 PM TAB 1 - SB 436 - Payment for Services Provided by Licensed Psychologists
3:07:58 PM Presentation by Grey Dodge
3:08:50 PM Presentation by Grey Dodge
3:08:51 PM Roll call on SB 436 - favorable
3:09:32 PM TAB 2 - CS/SM 1298 - Disaster Savings Account Act
3:10:03 PM Caitlin Murray recognized to explain the bill.
3:11:03 PM Sen. Lee recognized for a question
3:12:34 PM Roll call on CS/SM 1298 -- Favorable
3:14:41 PM James Knudson, Staff Director, gives presentation on Title Insurance
3:22:12 PM Monty Stevens, OIR, recognized to answer question posed by Senator Lee
3:27:34 PM TAB 5 by Sen. Hays - Reimbursement Allowances for Hospital Care
3:28:36 PM Senator Hays recognized to explain SB 1580
3:31:45 PM Amd. to Amd. (920234) to delete all amendment (809718) by Sen. Diaz de la Portia
3:35:47 PM Motion to withdraw amd. to amd. (920234) - Sen. Diaz de la Portia
3:36:29 PM Without objection to delete all amendment - favorable
3:37:04 PM Paul Anderson, Attorney, Fl Justice Association
3:38:45 PM Bill Bell, Gen. Counsel, FL Hospital Association
3:42:35 PM Carolyn Johnson, Policy Director, FL Chamber of Commerce
3:53:13 PM Senator Hays recognized to close on SB 1580
3:55:46 PM Motion for CS - Hays - w/o objection -
3:56:04 PM Roll call on CS/SB 1580 - Favorable
3:56:34 PM Meeting adjourned

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR JOE NEGRON
32nd District

COMMITTEES:
Appropriations, *Chair*
Banking and Insurance
Rules

SELECT COMMITTEE:
Select Committee on Indian River Lagoon and Lake Okeechobee Basin, *Chair*
Select Committee on Patient Protection and Affordable Care Act, *Chair*

JOINT COMMITTEE:
Joint Legislative Budget Commission, *Alternating Chair*

April 1, 2014

Chairman David Simmons
Committee on Banking & Insurance
320 Knott Building
Tallahassee, FL 32399

HAND DELIVERED

Re: Excused Absence Request

Dear Chairman Simmons:

This letter shall serve as my formal request for an excused absence from the Senate Committee on Banking & Insurance Meeting on Tuesday, April 1, 2014. This absence is necessary to attend to duties regarding pending issues on the General Appropriations Act.

Thank you for your consideration of this request.

Sincerely Yours,

Joe Negron
State Senator
District 32

JN/hd
c: James Knudson, Staff Director

REPLY TO:
☐ 3500 SW Corporate Parkway, Suite 204, Palm City, Florida 34990 (772) 219-1665 FAX: (772) 219-1666
☐ 412 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5032

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

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore