Committee on Banking and Insurance

CS/CS/HB 87 — Mortgage Foreclosures

by Appropriations Committee; Judiciary Committee; and Rep. Passidomo and others (CS/CS/SB 1666 by Judiciary Committee; Banking and Insurance Committee; and Senator Latvala)

Statute of Limitations on Certain Actions

The bill reduces the statute of limitations period for a lender to enforce a deficiency judgment following the foreclosure of a one-family to four-family dwelling unit from 5 years to 1 year, for any such deficiency action that commences on or after July 1, 2013, regardless of when the cause of action accrued.

The Foreclosure Complaint

The bill requires that in order to bring a complaint to foreclose a mortgage on residential real property designed principally for occupation by 1 to 4 families, including condominiums and cooperatives but excluding timeshare interests under part III of ch. 721, F.S., the complaint must establish that the plaintiff holds the original note or is a person entitled to enforce a promissory note. If a plaintiff has been delegated the authority to institute a foreclosure action on behalf of the person entitled to enforce the note, the complaint must describe with specificity the authority of the plaintiff and the document that grants such authority to the plaintiff.

A plaintiff in possession of the original promissory note must certify, under penalty of perjury, that the plaintiff possesses the original note. An "original note" or "original promissory note" is defined as the signed or executed promissory note, including a renewal, replacement, consolidation, or amended and restated note or instrument that substitutes for the previous promissory note. The term includes a transferrable record, but not a copy of any of the foregoing. The required certification must be submitted contemporaneously with the foreclosure complaint, and set forth the location of the note and other specified information. The original note and allonges must be filed with the court before the entry of any judgment of foreclosure or judgment on the note.

A plaintiff seeking to enforce a lost, destroyed, or stolen instrument must attach to the complaint an affidavit executed under penalty of perjury, detailing the chain of all endorsements, transfers, or assignments of the promissory note, and setting forth the facts and documents showing that the plaintiff is entitled to enforce the instrument. Adequate protection as required under s. 673.3091(2), F.S., must be provided before final judgment.

Finality of Mortgage Foreclosure Judgment

The bill provides that an action to challenge the validity of a final judgment of mortgage foreclosure, or to establish or re-establish a lien or encumbrance of property is limited to monetary damages if all of the following apply:

- The party seeking relief from the final judgment of mortgage foreclosure was properly served in the foreclosure lawsuit;
- The final judgment of mortgage foreclosure was entered as to the property;
- All applicable appeals periods have run as to the final judgment with no appeals having been taken or having been finally resolved; and
- The property has been acquired for value by a person not affiliated with the foreclosing lender or the foreclosed owner, at a time in which no lis pendens regarding the suit is in the official county records.

The bill defines affiliates of the foreclosing lender to include any loan servicer for the loan being foreclosed, and any past or present owner or holder of the loan being foreclosed, and:

- a parent entity, subsidiary, or other person who directly or indirectly controls, is controlled by, or under common control of any such entities; or
- a maintenance company, holding company, foreclosure services company or law firm under contract with such entities.

The bill provides that the former owner can continue to pursue money damages against the lender. The claims of the former owner, however, cannot impact the marketability of the property of the new owner.

The bill provides that when a foreclosure of a mortgage occurs based upon enforcement of a lost, destroyed, or stolen note, a person who was not a party to the foreclosure action but claims entitlement to enforce the promissory note secured by the mortgage has no claim against the foreclosed property once it is conveyed to a person not affiliated with the foreclosing lender or the foreclosed owner. That person may still pursue recovery from any adequate protection given pursuant to s. 673.3091, F.S., or from the party who wrongfully claimed entitlement to enforce the promissory note, from the maker of the note, or any other person against whom a claim may be made.

Deficiency Judgments

The bill limits the amount of a deficiency judgment on owner-occupied residential property to the difference between the judgment amount and the "fair market value" on the date of the foreclosure sale. Similarly, the deficiency for a short sale may not exceed the difference between the outstanding debt and the fair market value of the property on the date of the sale.

Show Cause Procedure

The bill makes several revisions to the show cause process. The bill provides that after filing a complaint, the plaintiff may request an order to show cause for the entry of final judgment, and the court must immediately review the request and the court file in chambers without a hearing. If the complaint is verified, complies with the requirements in s. 702.015, F.S., and alleges a

cause of action to foreclose on real property, the court must issue an order to show cause why a final judgment of foreclosure should not be entered to the other parties named in the action. The bill adds a number of elements that must be included in the court's order to show cause that is sent to the other parties named in the action. The court must set a hearing no sooner than the later of 20 days after service of the order to show cause or 45 days after service of the initial complaint. The hearing is no longer required to be held within 60 days of the date of service, as required by current law. The bill specifies that the Legislature intends that the alternative show cause procedure may run simultaneously with other court proceedings.

The bill adds the requirement that the plaintiff must file the original note, establish a lost note, or show the court the obligation to be foreclosed is not evidenced by a promissory note, before the court can enter a final judgment of foreclosure after the court has found that all defendants have waived the right to be heard. If the hearing time is insufficient, the court may announce a continued hearing on the order to show cause.

The bill exempts foreclosures of owner-occupied residences from provisions authorizing the plaintiff to request the court to enter an order to show cause why it should not enter an order to make payments during the pendency of the foreclosure proceedings, or an order to vacate the premises.

Adequate protections for lost, destroyed, or stolen notes

The bill provides that the following may constitute reasonable means of providing adequate protection, if so found by the court:

- A written indemnification agreement by a person reasonably believed sufficiently solvent;
- A surety bond;
- A letter of credit issued by a financial institution;
- A deposit of cash collateral with the clerk of the court; or
- Such other security as the court deems appropriate under the circumstances.

The bill provides that a person who wrongly claims to be the holder of a note or to be entitled to enforce a lost, stolen, or destroyed note is liable to the actual holder of the note for damages and attorney fees and costs. The bill specifies that the actual holder of the note can pursue any other claims or remedies it may have against the person who wrongly claimed to be the holder, or any person who facilitated or participated in the claim.

Application and Implementation of Bill

The Legislature finds that the act is remedial and not substantive in nature. The act applies to all mortgages encumbering real property and all promissory notes secured by a mortgage, regardless of when executed. The following sections are exempted from this general rule of application:

- Section 702.015, F.S., only applies to cases filed on or after July 1, 2013.
- The amendments to s. 702.10, F.S., and the entirety of s. 702.11, F.S., apply to causes of action pending on the act's effective date.

The Legislature also requests the Supreme Court to amend the Rules of Civil Procedure to implement the expedited foreclosure process.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 26-13; House 87-26

Committee on Banking and Insurance

CS/HB 95 — Charitable Contributions

by Regulatory Affairs Committee and Rep. Holder and others (CS/SB 102 by Banking and Insurance Committee and Senator Detert)

The bill defines "charitable contribution" consistent with the definition in the Internal Revenue Code (IRC), if the contribution is cash or a financial instrument defined in the IRC. The bill also defines "qualified religious or charitable entity or organization" consistent with the definition in the IRC.

The bill provides a statutory defense to a "clawback" action for a qualified religious or charitable entity or organization that demonstrates that the transfer was received in "good faith" when the transfer was received beyond 2 years from the commencement of an action under the Florida Uniform Fraudulent Transfer Act (FUFTA), the filing of a bankruptcy petition, or the commencement of an insolvency action. The bill, however, provides that a charitable contribution from a natural person is a fraudulent transfer if it was received within 2 years of the commencement of an action under FUFTA, the filing of a bankruptcy petition, or the commencement of an insolvency action. The bill provides an exception that such a transfer from a natural person within the 2 years is not fraudulent if the transfer was consistent with the practices of the debtor; or the transfer was received in good faith and the contribution did not exceed 15 percent of the gross income of the debtor.

If approved by the Governor, these provisions take effect on July 1, 2013.
Vote: Senate 35-2; House 114-0

Committee on Banking and Insurance

CS/HB 157 —Delivery of Insurance Policies

by Insurance and Banking Subcommittee and Rep. Holder (CS/SB 262 by Banking and Insurance Committee and Senator Smith)

The bill allows an insurer to use electronic transmission as an acceptable means to meet statutory requirements for delivery of an insurance policy. Under current law, an insurer must mail or deliver a policy to the insured within 60 days after the insurance takes effect. The bill further specifies electronic transmission of an insurance policy related to commercial risks constitutes delivery of the policy to the policyholder unless the policyholder notifies the insurance company in writing or in an electronic format that they do not agree to have their policy delivered by electronic transmission. If a policy covering commercial risks is transmitted to the policyholder electronically, the transmission is required to include notice to the policyholder indicating the policyholder has a right to receive the policy by mail instead of electronic transmission. In addition, a paper copy of the policy must be provided to policyholders upon request.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 38-0; House 115-0

Committee on Banking and Insurance

CS/CS/SB 166 — Annuities

by Judiciary Committee; Banking and Insurance Committee; and Senator Richter

The bill substantially revises Florida consumer protection laws relating to sales of annuities by incorporating the 2010 National Association of Insurance Commissioners (NAIC) model regulation on annuity protections. The bill expands the scope of the consumer protection laws to generally include all consumers purchasing annuities. Current law only applies the protections to consumers aged 65 and older. The bill also retains current law limiting the surrender charges and deferred sales charges that may be imposed upon senior consumers.

The following are primary consumer protections contained in the bill:

Suitability of Annuities – The bill requires an insurer or insurance agent recommending the purchase or exchange of an annuity that results in an insurance transaction to have reasonable grounds for believing the recommendation is suitable for the consumer, based on the consumer's suitability information. The bill imposes additional duties on insurers and insurance agents when a transaction involves the exchange or replacement of an annuity.

Documentation of Sales Transaction – The bill requires agents and agent representatives to record recommendations made to a consumer.

Prohibitions on Agents – The bill prohibits agents from dissuading or attempting to dissuade a consumer from truthfully responding to the insurer's request for suitability information, filing a complaint, or cooperating with the investigation of a complaint.

Unconditional Refund Period – The bill expands to 21 from 14 days the unconditional refund period for all purchasers of fixed and variable annuities.

Limit on Surrender Charges – The bill retains the prohibition against surrender charges or deferred sales charges in annuity contracts issued to a senior consumer exceeding 10 percent of the amount withdrawn. The charge must be reduced so that no surrender or deferred sales charge exists after the end of the 10th policy year or 10 years after the premium is paid, whichever is later.

Penalties – Authorizes the imposition of corrective action, appropriate penalties, and sanctions on insurers, agents, managing general agencies, or insurance agencies that violate the requirements of s. 627.4554, F.S. An insurance agent must pay restitution to a consumer whose money the agent misappropriates, converts, or unlawfully withholds.

If approved by the Governor, these provisions take effect October 1, 2013.
Vote: Senate 40-0; House 116-0

Committee on Banking and Insurance

CS/CS/HB 217 — Money Services Businesses

by Government Operations Appropriations Subcommittee; Insurance and Banking Subcommittee; Reps. Cummings, Oliva, and others (CS/SB 410 by Appropriations Committee and Senator Bean)

The bill provides for the establishment of a check-cashing database within the Office of Financial Regulation (OFR). The database can be used by regulators and law enforcement agencies to target and identify persons involved in workers' compensation insurance premium fraud and other criminal activities. The OFR regulates money services businesses that offer financial services, such as check cashing, money transmittals (wire transfers), sales of monetary instruments, and currency exchange outside the traditional banking environment. Currently, licensed check cashers are required to maintain specified records, such as copies of all checks cashed, and for checks exceeding $1,000, certain transactional data in an electronic log.

The bill authorizes the OFR to issue a competitive solicitation for a statewide, real time, online check cashing database. The bill requires that check cashers, after implementation of the new database, to enter specified transactional information into the database. After completion of the competitive solicitation for the database, the OFR may include a request for funding in their FY 2014-2015 Legislative Budget Request. The bill has no fiscal impact on state government for the 2013-2014 fiscal year.

The bill also grants rulemaking authority to the Financial Services Commission to administer these provisions and requires money services businesses to submit additional information to the database.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 39-0; House 114-0

Committee on Banking and Insurance

CS/HB 223 — Insurance

by Insurance and Banking Subcommittee and Rep. Lee (CS/SB 418 by Commerce and Tourism Committee and Senator Detert)

The bill allows property and casualty insurance policies and endorsements that do not contain personally identifiable information may be posted on the insurer's Internet website. If the insurer elects to post insurance policies and endorsements on its Internet website the insurer must:

- Make each policy and endorsement easily accessible on the insurer's Internet website for as long as the policy and endorsement remain in force.
- Archive all of its expired policies and endorsements on its Internet website and make any expired policy and endorsement available upon an insured's request for at least 5 years after expiration of the policy and endorsement.
- Post each policy and endorsement in a manner that enables the insured to print and save the policy and endorsement using a program or application that is widely available on the Internet without charge.
- Notify the insured, in the manner the insurer customarily uses to communicate with the insured, that the insured has the right to request and obtain without charge a paper or electronic copy of the insured's policy and endorsements.
- Clearly identify the exact policy form and endorsement form purchased by the insured on each declarations page issued to the insured.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 37-0; House 116-0

Committee on Banking and Insurance

SB 282 — Consumer Finance Charges

by Senator Richter

The bill amends ch. 516, F.S., the Florida Consumer Finance Act (act), which governs consumer finance loans. The act defines "consumer finance loan" as a loan of money, credit, goods, or provisions of a line of credit, in an amount or to a value of $25,000 or less at an interest rate greater than 18 percent per annum. The allowable interest rates on consumer finance loans are tiered and limited based on the principal amount that falls within each tier of the loan. As the principal amount increases, the allowable interest rate decreases, as follows:

- On the first $2,000 of principal, up to 30 percent allowable interest;
- From $2,001 to $3,000 of principal, up to 24 percent allowable interest; and
- From $3,001 to $25,000 of principal, up to 18 percent allowable interest.

The bill increases by $1,000 the principal amount that would be subject to the maximum amount of interest that is allowed to be charged within each tier. The bill increases from $10 to $15, the maximum amount that can be charged to a borrower for making a payment that is in default for at least 10 days.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 31-3; House 109-6

Committee on Banking and Insurance

CS/HB 341 — Uninsured Motorist Insurance Coverage

by Regulatory Affairs Committee and Rep. Ingram and others (SB 706 by Senator Montford)

The bill deals with the rejection of stackable Uninsured Motorist (UM) motor vehicle insurance benefits. Current law states that when the named insured, applicant, or lessee signs a form rejecting UM coverage, a conclusive presumption arises that "there was an informed knowing acceptance of such limitations" of coverage. The bill specifies that the signed form gives rise to a conclusive presumption that the rejection of stackable coverage benefits was made "on behalf of all insureds." The bill addresses the decision of the Florida First District Court of Appeal in *Travelers Commercial Insurance Company v. Harrington*, 86 So.3d 1274 (Fla. 1st DCA 1012). In *Harrington*, the Court determined that stackable UM coverage benefits are available to an insured claimant under an insurance policy where the purchaser executed a signed waiver of stacking benefits, but the insured claimant did not waive such benefits.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 38-0; House 117-0

Committee on Banking and Insurance

SB 356 — Mutual Insurance Corporations

by Senator Abruzzo

The bill allows a financial guaranty insurance corporation to be organized as a mutual insurer. If the corporation is organized as a mutual insurer, it must be organized and licensed in accordance with the provisions of the Florida Insurance Code. Financial guaranty insurance is a surety bond, insurance policy, or indemnity contract issued by an insurer, or a similar guaranty, under which loss is payable once the insured claimant, obligee, or indemnitee provides proof of an occurrence of:

- The failure, as a result of a financial default or insolvency of an obligor on a debt instrument or other monetary obligation to make principal, interest, premium, dividend, or purchase price payments when due;
- Changes in interest rate levels or the differential in interest rates between various markets or products;
- Changes in currency exchange rates;
- Changes in the value of specific assets or commodities, financial or commodity indices, or price levels in general; or
- Other events that the Office of Insurance Regulation determines are substantially similar to any of the foregoing.

The bill permits a mutual insurance holding company to acquire the membership interests of a not-for-profit insurance company or nonprofit health care plan. The mutual insurance holding company may also acquire a not-for-profit insurance company or nonprofit health care plan through the merger of such entities with a mutual insurance company or a not-for-profit insurance company subsidiary of the mutual insurance holding company or intermediate holding company. The bill allows a not-for profit insurance company subsidiary to pay dividends or distributions to its mutual insurance holding company.

If approved by the Governor, except as otherwise provided, these provisions take effect upon becoming law.
Vote: Senate 38-0; House 112-0

Committee on Banking and Insurance

CS/CS/HB 383 — Interstate Insurance Product Regulation Compact

by Regulatory Affairs Committee; Insurance and Banking Subcommittee; and Rep. Hudson and others (CS/CS/CS/SB 242 by Appropriations Committee; Governmental Oversight and Accountability Committee; Banking and Insurance Committee; and Senator Hukill)

The bill enacts the Interstate Insurance Product Regulation Compact (Compact). The Compact is intended to help states join together to regulate designated insurance products, specifically, the following asset-based insurance products:

- Life insurance;
- Annuities;
- Disability income insurance; and
- Long-term care insurance, though the state is prospectively opting out of all uniform standards for long-term care insurance in the Compact.

The Compact is governed by the Interstate Insurance Product Regulation Commission (Commission). The Commission may:

- Develop uniform standards for product lines;
- Receive and promptly review products; and
- Approve product filings that satisfy applicable uniform standards.

The members of the Commission are representatives from each state that has joined the Compact. The Commission has authority to adopt uniform standards by rule. A "uniform standard" is a commission standard for a product line, plus subsequent amendments that use a substantially consistent methodology. A uniform standard includes all product requirements in the aggregate. A uniform standard must be construed to prohibit the use of inconsistent, misleading, or ambiguous provisions in a product. The uniform standard must also ensure that the form of any product made available to the public is not unfair, inequitable, or against public policy as determined by the Commission. Adoption of a uniform standard requires a two-thirds vote of Commission members.

The Commission also has authority to receive and review products filed with the Commission and rate filings for disability income and long-term care insurance products (Florida is opting out of all uniform standards involving long-term care). Products and disability income insurance rates that satisfy the appropriate uniform standard may be approved. Commission approval has the force and effect of law and is binding on compacting states. A product is the policy form or contract and includes any application, endorsement, or related form that is attached to and part of the policy or contract. The term also includes any evidence of coverage or certificate for an individual or group annuity, life insurance, disability income, or long-term care insurance product that an insurer is authorized to issue. A state may opt out of a uniform standard via legislation or rule. Florida is prospectively opting out of all uniform standards involving long-term care insurance products, as allowed by the terms of the Compact.

To obtain approval of a product, the insurer must file the product with the Commission and pay applicable fees. Any product approved by the Commission may be sold or otherwise issued in any compacting state in which the insurer is authorized to do business. An insurer may alternatively file its product with a state insurance department, and such filing will be subject to the laws of that state.

All lawful actions of the Commission, including all rules and operating procedures, are binding on compacting states. Agreements between the Commission and compacting states are binding in accordance with their terms. The Compact prevents the enforcement of any other law of a compacting state, except that the Commission may not abrogate or restrict the access to state courts; remedies related to breach of contract, tort, or other laws not specifically directed to the content of the product; state law relating to the construction of insurance contracts; or the authority of the state Attorney General. A Compact provision is ineffective as to a state, however, if it exceeds the constitutional limits imposed on the Legislature of a state. If an insurance product is filed with an individual state, it is subject to the law of that state.

The exclusivity provision of the Compact (stating that the rules and uniform standards of the compact are the exclusive provisions applicable to the content, approval, and certification of products governed by the Compact) applies only to uniform standards adopted by the Commission, and standards adopted by Florida are not limited or rendered inapplicable by the absence of a standard adopted by the Commission. The bill also applies all Florida standards to the content, approval, and certification of products in Florida, notwithstanding the exclusivity provision of the Compact.

The state exercises an opt out of all new uniform standards that the Commission adopts after March 1, 2013, that substantially alter or add to existing Commission uniform standards that the state adopted pursuant to this bill until the state enacts legislation to adopt or opt out of the new uniform standards or amendments to uniform standards. Effective July 1, 2014, the state will exercise an opt-out of uniform standards adopted by the Commission for the 10-day period for the unconditional refund of life insurance premiums, plus any fees or charges under s. 626.99, F.S.; underwriting criteria limiting the amount, extent, or kind of life insurance based on past or future travel that is inconsistent with s. 626.9541(1)(dd), F.S., as implemented by the Office of Insurance Regulation (OIR); and any Compact standard that conflicts with Florida statutes or rules providing consumer protections.

The OIR must prepare a report that examines the extent to which Compact standards provide consumer protections equivalent to those under state law and the Administrative Procedure Act for annuity, life insurance, disability income, and long-term care insurance products. The OIR must submit the report to the Senate President, the Speaker of the House of Representatives, and the Financial Services Commission by January 1, 2014.

If approved by the Governor, except as otherwise provided, these provisions take effect July 1, 2014.
Vote: Senate 39-0; House 116-0

Committee on Banking and Insurance

CS/CS/HB 457 — Collection of Worthless Payment Instruments

by Business and Professional Regulation Subcommittee; Civil Justice Subcommittee; and Rep. Magar (CS/SB 550 by Banking and Insurance Committee and Senator Simpson)

The bill amends s. 68.065, F.S., to define the term "payment instruments" to include debit card transactions and electronic funds transfers. The bill also provides an alternative collection process that allows a payee to collect on payment instruments without having to file a civil action. Specifically, if the payment is refused or the maker has stopped payment on the payment instrument with intent to defraud, the payee may collect:

- Bank fees actually incurred by the payee in the course of tendering payment; and
- A service charge which is the greater of 5 percent of the amount of the payment instrument or $25 if the payment amount is $50 or less, $30 if the payment instrument amount is greater than $50 but less than or equal to $300, or $40 if the payment instrument amount is greater than $300.

The alternative collection process does not prevent the payee from bringing a civil action to collect three times the face value of the payment instrument, plus costs, attorney fees, and bank fees. To do so, however, the payee will need to provide written notice to the maker of the payment instrument and allow the maker 30 days to cure by paying the face value of the payment instrument and the statutorily defined service fee.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 40-0; House 96-18

Committee on Banking and Insurance

CS/SB 464 — Disposition of Unclaimed Property

by Governmental Oversight and Accountability Committee and Senator Flores

The bill authorizes the Department of Financial Services to adopt rules to allow an apparent owner of unclaimed property to electronically submit a claim to the department. If the electronically submitted claim is for $1,000 or less, the department may use an alternative method of identity verification. The bill also applies the procedures of ch. 717, F.S., to property reported or remitted by the Chief Financial Officer pursuant to:

- Section 43.19, F.S., Money Paid into Court; Unclaimed Funds: Provides that unclaimed funds held in the court registry for 5 years shall be deposited with the Chief Financial Officer to the credit of the State School Fund. Accounts/funds held in perpetuity.

- Section 45.032, F.S., Disbursement of Surplus Funds after Judiciary Sale: Provides that unclaimed funds as a result of a property foreclosure are to be deposited with the Chief Financial Officer. Accounts/funds held in perpetuity.

- Section 732.107, F.S., Escheat: Property held by an Estate without Heirs escheats' to the state. Accounts/funds can be claimed for 10 years, after which the funds permanently escheat.

- Section 733.816, F.S., Disposition of Unclaimed Property Held by Personal Representatives: Property held by a Personal Representative that cannot be distributed to a beneficiary is deposited into the court registry and then deposited with the Chief Financial Officer. Accounts/funds can be claimed for 10 years, after which the funds permanently escheat.

- Section 744.534, F.S., Disposition of Unclaimed Funds Held by Guardian: Property held by a Legal Guardian that cannot be distributed to a ward or ward's estate is deposited into the court registry and then is deposited with the Chief Financial Officer. Accounts/funds can be claimed for 5 years, after which the funds permanently escheat.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 39-0; House 117-0

Committee on Banking and Insurance

CS/CS/SB 468 — Property and Casualty Insurance Rates, Fees, and Forms

by Health Policy Committee; Banking and Insurance Committee; and Senator Hukill

CS/CS/SB 468 expands the number of commercial lines insurance that are exempt from the rate filing and review requirements of s. 627.062(2)(a) and (f), F.S, to include:

- Medical malpractice for a facility that is not a hospital, nursing home, or assisted living facility.
- Medical malpractice for a health care practitioner that is not a licensed dentist, physician, osteopathic physician, chiropractic physician, podiatric physician, pharmacist, or pharmacy technician.

The rate filing requirements that these types of medical malpractice insurance are exempt from are:

- The requirement to file with the Office of Insurance Regulation (OIR) rates, rating schedules, or rating manuals via the "file and use" method (at least 90 days prior to the proposed effective date) or the "use and file" method (within 30 days after the effective date of the filing).
- The authority of the OIR to require an insurer to provide, at the insurer's expense, all information necessary to evaluate the condition of the company and the reasonableness of the rate filing.

The bill creates an alternative mechanism to the form filing and approval process required by s. 627.410, F.S., for all lines of property and casualty insurance, except workers' compensation and personal lines. Insurers may instead elect to make an informational form filing in which a representative of the insurer executes a sworn certification that the filed forms comply with Florida law if:

- The form is electronically submitted to the OIR in an informational filing 30 days before delivery of the form within the state; and
- The informational filing includes a certification of compliance.

If the form is not in compliance with state laws and rules, the form filing is subject to the prior approval requirements of s. 627.410, F.S. A Notice of Change in Policy Terms form is also required as a part of the informational filing for any renewal policy that contains a change.

The bill also extends the exemption of medical malpractice insurance policies from Florida Hurricane Catastrophe Fund emergency assessments until May 31, 2016. The exemption was scheduled to expire May 31, 2013.

If approved by the Governor, these provisions take effect July 1, 2013
Vote: Senate 31-5; House 89-26

Committee on Banking and Insurance

CS/CS/HB 553 — Workers' Compensation System Administration

by Government Operations Appropriations Subcommittee; Insurance and Banking Subcommittee; Rep. Hager and others (CS/SB 860 by Banking and Insurance Committee and Senator Galvano)

The bill provides the following changes relating to the administration of workers' compensation system in Florida:

- Provides that stop-work orders and penalties assessed against a limited liability company (LLC) continue in force against successor companies of the LLC to the same extent (and under the same conditions) that they remain in force against successor companies of corporations, partnerships, and sole proprietorships.
- Eliminates the requirement that workers' compensation health care providers be certified by the Department of Financial Services (DFS).
- Provides additional time for health care providers, carriers, and employers to file medical reimbursement disputes with the DFS, for carriers to respond to petitions, and for the DFS to issue a written determination.
- Eliminates the requirements that: (1) the DFS approve the advance payment of workers' compensation benefits in certain circumstances; (2) carriers submit reemployment status reports to the DFS for review; (3) a vocational evaluation always be conducted prior to the DFS authorizing training and education for an injured employee; and (4) the DFS serve as custodian of certain collective bargaining agreements.
- Conforms the administrative fine under s. 440.185(9), F.S., that may be assessed against employers or carriers that violate reporting requirements with the $500 civil penalty per violation provided under s. 440.593(4), F.S., relating to electronic reporting. Currently, s. 440.185(9), F.S., provides for an administrative fine of up to $1,000 per violation and, for employers that fail to timely submit more than 10 percent of notices of injury or death within a calendar year, an administrative fine of up to $2,000 per violation. The DFS uses their authority under s. 440.185(9), F.S., to assess penalties for violations of reporting requirements, but it has never assessed a penalty greater than $500 per violation or against an employer based upon a percentage of late filings.

The elimination of the mandatory vocational evaluation pursuant to s. 440.491, F.S., will result in a reduction of $80,000 in state expenditures.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 38-1; House 114-1

Committee on Banking and Insurance

SB 558 — Letters of Credit Issued by a Federal Home Loan Bank

by Senator Detert

The bill amends the Florida Security for Public Deposits Act (the act), which authorizes local and state governments to place public deposits in qualified public depositories (QPD). The state Chief Financial Officer (CFO) is responsible for establishing criteria for financial institutions to be designated QPDs. A QPD is required to secure or collateralize public deposits in accordance with the act. Various types of securities are eligible to be pledged as collateral, including letters of credit issued by a Federal Home Loan Bank (FHLBank) that are triple A-rated (AAA), which is the highest rating, by a national source.

Due to uncertainties regarding the fiscal condition of the United States (U.S.), consumer confidence, high unemployment, and the global economy, one of the nationally recognized credit rating agencies, Standard and Poor's Ratings Services (Standard & Poor's), downgraded the U.S. long-term sovereign credit rating one level from "AAA" to "AA+." While Moody's Investor Service, Inc., and Fitch, Inc., have not downgraded the U.S. sovereign rating, they have both issued short-term negative outlooks for the U.S. and have indicated that they may downgrade the U.S. from its top credit rating if Congress fails to address those fiscal issues. Although the U.S. government does not guarantee obligations of the FHLBank, a government-sponsored entity, credit rating agencies state that there is financial dependence between the U.S. government and the FHLBank. Thus, a lower U.S. sovereign rating would likely affect the rating of the FHLBank. In the event the two other rating agencies also downgrade their credit ratings for FHLBank obligations, QPDs could no longer use FHLBank letters of credit as eligible collateral under current law. This would require QPDs to use other assets as replacement collateral, which in turn could affect their liquidity and lending ability.

The bill would allow QPDs to continue using letters of credit of a FHLBank as eligible collateral in the event the other major credit agencies downgrade their ratings of FHLBank obligations below AAA. The bill would permit QPDs to use letters of credit of an FHLBank, if obligations of the FHLBank are rated by a nationally recognized source at not lower than its rating of the long-term sovereign credit of the U.S.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 40-0; House 116-0

Committee on Banking and Insurance

CS/CS/CS/HB 573 — Manufactured and Mobile Homes

by Regulatory Affairs Committee; Government Operations Appropriations Subcommittee; Insurance and Banking Subcommittee; and Rep. Hooper and others (CS/SB 378 by Banking and Insurance Committee and Senators Bean, Latvala, Grimsley, and Detert)

The bill imposes a $3,000 minimum insured value, instead of $6,000. Thus, Citizens is required to offer coverage for mobile and manufactured homes for a minimum insured value of at least $3,000. This minimum applies to buildings, other structures, contents, additional living expense, and liability coverage for owner occupied mobile or manufactured homes. And, it applies to contents, additional living expense, and liability coverage provided to a renter or tenant of a mobile or manufactured home.

In addition, the bill requires Citizens to provide coverage for the following attached structures to mobile or manufactured homes:

- Screened enclosures that are aluminum framed or screened enclosures that are not covered by the same or substantially the same materials as that of the primary dwelling.
- Carports that are aluminum or carports not covered by the same or substantially the same materials as that of the primary dwelling.
- Patios that have a roof covering constructed of materials that are not the same or substantially the same materials as that of the primary dwelling.

The bill amends s. 723.06115, F.S., to specify the manner in which funds from the Florida Mobile Home Relocation Trust Fund are to be disbursed to the Florida Mobile Home Relocation Corporation.

Specifically, the bill provides that the Department shall disburse funds from the Trust Fund to the Corporation using the following procedures:

- At the beginning of each fiscal year, the Corporation shall determine its operating costs and provide that amount to the Department, in writing. One-fourth of the operating budget shall be transferred to the Corporation each quarter. The Department shall make the first one-fourth quarter transfer on the first business day of the fiscal year and make the remaining one-fourth transfers before the second business day of the second, third, and fourth quarters.
- Throughout the year, additional requests for necessary operating funds may be submitted to the Department, in writing, indicating the changes to the operating budget and the conditions that were unforeseen at the time the Corporation developed the operating budget at the beginning of the fiscal year.
- As it deems necessary, the Corporation shall advise the Department, in writing, of the amount needed to make payments to mobile home owners under the relocation program. The Department must distribute the amount within 5 business days of the Corporation's written request. Funds transferred from the Department to the Corporation shall be

transferred electronically and maintained by the Corporation in a qualified public depository as defined in s. 280.02, F. S.

Finally, the bill specifies that other than the requirements set forth in the section, neither the Corporation nor the Department is required to take any other action as a prerequisite to accomplishing the provisions of this section. This effectively nullifies any additional disbursement "prerequisites" listed in the current Memorandum of Understanding between the Department and the Corporation.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 38-0; House 117-1

Committee on Banking and Insurance

CS/SB 648 — Health Insurance Marketing Materials

by Banking and Insurance Committee and Senator Hukill

The bill eliminates the requirement that health insurers and health maintenance organizations submit marketing communications for small employer health plans to the Office of Insurance Regulation (OIR) for review. The bill also deletes the requirement that each marketing communication contain specific disclosures, but retains the requirement that such disclosure be provided to a small employer upon the offer of coverage.

The bill continues the requirement that insurers file with the OIR any long-term care insurance advertising materials, but deletes the requirement to file such materials 30 days prior to use. The bill allows the insurer to begin using such materials upon filing, subject to subsequent disapproval by the OIR. The bill does not eliminate the authority of the Financial Services Commission to adopt rules establishing standards for the advertising, marketing, and sale of long-term care insurance policies.

Florida law would continue to prohibit persons involved in the business of insurance from knowingly publishing any advertising with respect to the business of insurance, which is untrue, deceptive, or misleading.

The bill also specifies that the rules adopted by the Financial Services Commission to establish the format for the notice of the estimated premium impact of the federal Patient Protection and Affordable Care Act (PPACA) are not subject to s. 120.541(3), F.S., which requires that rules obtain legislative ratification if they exceed certain regulatory costs. These rules are required to be adopted pursuant to CS/SB 1842, which was passed by the Legislature on April 26, 2013, and ordered enrolled. That bill requires health insurers and health maintenance organizations to provide a notice to individual and small group policyholders of nongrandfathered health plans that describes or illustrates the estimated impact of PPACA on monthly premiums. This notice would be required one time, when the policy is issued or renewed on or after January 1, 2014, and must first be filed with the OIR by September 1, 2013. The notice must be in a format established by rule by the Financial Services Commission. The OIR and the Department of Financial Services must develop a summary of the estimated impact of PPACA on monthly premiums as contained in the notices, which must be available on their respective websites by October 1, 2013.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 40-0; House 103-11

Committee on Banking and Insurance

CS/SB 662 — Workers' Compensation

by Appropriations Committee and Senator Hays

The bill revises provisions relating to reimbursement for prescription medications under ch. 440, F.S., Florida's Workers' Compensation Law in the following manner:

- Revises the amount of reimbursement for prescription medications of workers' compensation claimants by providing that the reimbursement rate for repackaged or relabeled drugs dispensed by a dispensing practitioner would be capped at 112.5 percent of the average wholesale price (AWP), plus $8.00 for the dispensing fee.
- Maintains the reimbursement rate for other prescription medications at AWP plus $4.18 dispensing fee.
- Provides that the AWP would be calculated by multiplying the number of units dispensed times the per-unit AWP set by the original manufacturer of the underlying drug dispensed, based upon the published manufacturer AWP published in the Medi-Span Master Drug Database as of the date of dispensing.
- Provides an exception to the reimbursement schedule if the employer or carrier, or a third party acting on behalf of the employer or carrier, directly contracts with a provider seeking reimbursement at a lower rate.
- Prohibits a dispensing practitioner from possessing such medications unless payment has been made to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing practitioner taking possession of the medication.

Chapter 440, F.S., generally requires employers and carriers to provide medical and indemnity benefits to workers who are injured due to an accident arising out of and during the course of employment. Medical benefits can include, but are not limited to, medically necessary care and treatment, and prescription medications. In Florida, the prescription reimbursement rate for dispensing physicians and pharmacies is the AWP plus a $4.18 dispensing fee, or the contracted rate, whichever is lower.

The National Council on Compensation Insurance estimates that the implementation of the bill would reduce workers' compensation insurance costs by 0.7 percent or approximately $20 million based on preliminary 2012 statewide workers' compensation insurance premium (insurers and self-insurers).

The Division of Risk Management in the Department of Financial Services estimates that implementation of the bill would result in an estimated annual increase in prescription drug costs of $210,377 to the State Risk Management Program.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 39-0; House 115-0

Committee on Banking and Insurance

CS/CS/HB 665 — Licensure by the Office of Financial Regulation

by Regulatory Affairs Committee; Insurance and Banking Subcommittee; and Rep. LaRosa and others (CS/SB 644 by Banking and Insurance Committee and Senator Richter)

The bill allows the Office of Financial Regulation (OFR) to exercise discretion regarding whether to deny an application for licensure as a mortgage broker or mortgage lender if the applicant's licensure or its equivalent was revoked in any jurisdiction. Current law requires the automatic denial of the licensure application. The bill also changes the method by which the OFR collects fingerprints from applicants for registration as securities dealers, associated persons, or securities issuers and applicants for money services business licensure. The new method of fingerprinting is live-scan processing. Money services business licensees initially approved for licensure before October 1, 2013, must re-submit fingerprints for live scan processing in order to obtain a renewed license set to expire between April 30, 2014, and December 31, 2015.

If approved by the Governor, except as otherwise provided, these provisions take effect October 1, 2013
Vote: Senate 39-0; House 118-0

Committee on Banking and Insurance

CS/CS/SB 810 — Wrap-Up Insurance Policies

by Commerce and Tourism Committee; Banking and Insurance Committee; and Senator Simmons

CS/CS/SB 810 defines a "wrap-up insurance policy" to mean a consolidated insurance program or series of insurance policies issued to the nonpublic owner or general contractor (or a combination of the two) of a construction project through a consolidated insurance program that provides workers' compensation coverage, various forms of liability coverage, or a combination of such coverages for the contractors and subcontractors working at a specified contracted work site of the construction project.

The bill authorizes a wrap-up insurance policy to include a deductible of $100,000 or more for workers' compensation claims if all of the following prerequisites are met:

- The workers' compensation minimum standard premium calculated on the combined payrolls for all entities covered by the wrap-up policy exceeds $500,000;
- The estimated cost of the construction at each specified contracted worksite is $25 million or more;
- The insurer pays the first dollar of a workers' compensation claim without a deductible;
- The reimbursement of the deductible by the insured does not affect the insurer's obligation to pay claims;
- The insurer complies with all workers' compensation filing requirements under ch. 440, F.S., for losses, including those below the deductible limit;
- The insurer files unit statistical reports with the National Council on Compensation Insurance (NCCI) which show all losses, including those below the deductible limit;
- Any unit statistical report needed to calculate an experience modification factor for the insured are filed with the NCCI;
- The insurer complies with NCCI aggregate financial calls, detail claim information calls, unit statistical reporting, and other required calls; and
- The insurer establishes a program for having the first-named insured, whether the owner, the general contractor, or a combination thereof, reimburse the insurer for losses paid within the deductible.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 40-0; House 115-0

Committee on Banking and Insurance

HB 913 — Holocaust Victims Assistance Act

by Reps. Bileca, Rader, and others (SB 936 by Senators Lee, Margolis, Sobel, and Sachs)

The bill expands the scope of assistance that is provided by the Department of Financial Services (DFS) to Holocaust victims and their heirs. While current law provides the DFS with the authority to assist Holocaust victims and their heirs in identifying and obtaining potential and actual insurance claims, the bill broadens the authority to include:

- Recovery of other financial claims, assets, and property;
- Education to mitigate the effects on Holocaust survivors of the nonpayment of claims or the nonreturn of property; and
- Assistance with gaining access to funding to address the effects of nonpayment of claims and nonreturn of confiscated assets.

The bill eliminates the annual report required of insurers and instead requires insurers to file a report with the DFS when there are any changes to the previous report, or when it is requested to do so by the DFS. The bill also specifies that the DFS must submit its annual report to the Legislature by July 1.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 38-0; House 119-0

Committee on Banking and Insurance

CS/HB 1191 — Captive Insurance

by Insurance and Banking Subcommittee and Rep. Nelson (CS/CS/SB 1408 by Appropriations Committee, Banking and Insurance Committee, and Senator Richter)

Current law requires that to be a qualifying reinsurer parent company, a reinsurer must hold a certificate of authority or a letter of eligibility, or be an accredited or satisfactory non-approved reinsurer. The bill removes the current allowance for a satisfactory non-approved reinsurer or a reinsurer that possesses a letter of eligibility to be acceptable alternatives to qualify as being a qualifying reinsurer parent company. The bill, however, adds the alternative that if a reinsurer qualifies for credit for reinsurance under s. 624.610(3), F.S., it will be considered a qualifying reinsurer parent company, even if it does not hold a certificate of authority.

Current law allows an industrial insured captive insurance company to insure only the risks of the industrial insureds that comprise the industrial insured group and their affiliated companies. The bill broadens the entities that an industrial insured captive insurance company is allowed to insure to include the industrial insureds' and affiliates' stockholders or members, and affiliates thereof, or the stockholders or affiliates of the parent corporation of the captive insurance company. The bill allows an industrial insured captive insurance company with unencumbered capital and surplus of at least $20 million to be licensed to provide workers' compensation and employer's liability insurance in excess of $25 million in the annual aggregate.

The bill exempts captive insurance companies from the statutory trust deposit required under s. 624.411, F.S., as a condition of obtaining a certificate of authority to transact insurance. A pure captive insurance company must submit to the Office of Insurance Regulation its standards to ensure a parent or affiliated company is able to exercise control of the risk management function of any controlled unaffiliated business that is to be insured by the pure captive insurance company. The bill deletes the current authorization for the Financial Services Commission to adopt rules establishing such standards.

If approved by the Governor, these provisions take effect July 1, 2013.
Vote: Senate 38-0; House 116-0

Committee on Banking and Insurance

CS/CS/SB 1410 — Fire Safety and Prevention

by Community Affairs Committee; Banking and Insurance Committee; and Senator Simmons

The bill makes changes to ch. 633, F.S., Fire Prevention and Control, which is administered by the Division of State Fire Marshal within the Florida Department of Financial Services. The bill:

- Revises provisions relating to the authority of the State Fire Marshal.
- Revises the renewal period for firesafety inspector certification from 3 years to 4.
- Revises provisions relating to the disciplinary authority of the State Fire Marshal.
- Authorizes the State Fire Marshal to deny, suspend, or revoke the licenses of certain persons, and provides terms and conditions of probation.
- Revises provisions relating to hearings, investigations, and recordkeeping duties and the authority of the State Fire Marshal.
- Requires the State Fire Marshal to investigate an fire or explosion resulting in property damage and to keep records from such investigations.
- Revises provisions relating to the authority of agents of the State Fire Marshal.
- Clarifies provisions relating to impersonating the State Fire Marshal, a firefighter, a firesafety inspector, or a volunteer firefighter, for which a criminal penalty is provided.
- Provides penalties for rendering a fire protection system inoperative and provides penalties for using a certificate issued to another person.
- Revises provisions to include investigation of explosions in fraudulent insurance claim investigations.
- Authorizes the State Fire Marshal to adopt rules to implement provisions relating to an insurance company's investigation of a suspected explosion by intentional means.
- Requires the division to establish by rule:
  - uniform minimum standards for the employment and training of firefighters and volunteer firefighters;
  - minimum curriculum requirements and criteria for the approval of education or training providers;
  - standards for the approval, denial of approval, probation, suspension, and revocation of approval of education or training providers and facilities for training firefighters and volunteer firefighters;
  - standards for the certification, denial of certification, probation, and revocation of certification for instructors; and,
  - minimum training qualifications for persons serving as specified firesafety coordinators.
- Requires the division to issue specified licenses, certificates, and permits.
- Requires notification of any felony actions against a licensee, permittee, or certificateholder.
- Revises terminology to provide for declaratory statements rather than formal interpretations in nonbinding interpretations by the division regarding the Florida Fire Prevention Code.

- Provides that a special district may enact any ordinance relating to firesafety codes that is identical to ch. 633, F.S., or any state law, except as to penalties.
- Clarifies persons authorized to inspect buildings and structures.
- Revises requirements of persons conducting firesafety inspections.
- Increases from 3 to 4 the number of years a fire safety inspector certificate is valid.
- Increases the continuing educations requirements for a fire safety inspector certificate from 40 hours to 54 hours.
- Requires the department to provide by rule for the certification of Fire Code Administrators.
- Authorizes, rather than requires, the State Fire Marshal or agents thereof to conduct performance tests on any electronic fire warning and smoke detection system, and any pressurized air-handling unit, in any state-owned building or state-leased building or space on a recurring basis.
- Requires the State Fire Marshal or agents thereof to ensure that fire drills are conducted in all high-hazard state-owned buildings or high-hazard state-leased occupancies at least annually.
- Authorizes the division to inspect state-owned buildings and spaces and state-leased buildings and spaces as necessary before occupancy or during construction, renovation, or alteration to ascertain compliance with uniform firesafety standards.
- Authorizes the Florida Fire Safety Board to review complaints and make recommendations, and, provides for the election of officers, quorum, and compensation of the board and requires the board to adopt a seal.
- Provides conditions that an applicant for a license of any class who has facilities located outside the state must meet in order to obtain a required equipment inspection.
- Provides for the adoption of rules with respect to the establishment and calculation of inspection costs.
- Revises and clarifies provisions that exclude from licensure for a specified period applicants having a previous criminal conviction and defines the term "convicted."
- Revises provisions that authorize the State Fire Marshal to suspend a fire protection system contractor's or permittee's certificate.
- Provides for an additional member of the Firefighters Employment, Standards, and Training council to be added from the Florida Forest Service; provides for organization of the council and its meetings, and compensation; and provides for special powers of the council in connection with the employment and training of firefighters.
- Specifies classes of certification awarded by the division and authorizes the division to establish specified additional certificates by rule, and:
  - Revises provisions relating to firefighter and volunteer firefighter training and certification.
  - Requires the division to establish by rule specified courses and course examinations.
  - Provides that courses may only be administered by specified education or training providers and taught by certified instructors.
  - Revises provisions with respect to payment of training costs and payment of tuition for attendance at approved courses.

  - Provides requirements for issuance by the division of a firefighter and volunteer firefighter certificate of compliance.
  - Authorizes the division to issue a Special Certificate of Compliance and provides requirements and limitations with respect thereto.
  - Increases the required number of hours of the structural fire training program from 40 to 54 hours.
  - Provides for a Forestry Certificate of Compliance and prescribes the rights, privileges, and benefits thereof.
  - Revises provisions relating to disqualifying offenses and provides requirements of the division with respect to suspension or revocation of a firefighter certificate.
- Prohibits a fire service provider from employing an individual as a firefighter or supervisor of firefighters and from retaining the services of an individual volunteering as a firefighter or a supervisor of firefighters without required certification.
- Requires a fire service provider to notify the division of specified hirings, retentions, terminations, decisions not to retain a firefighter, and determinations of failure to meet certain requirements.
- Authorizes the division to conduct site visits to fire departments to monitor compliance.
- Requires the State Fire Marshal to determine, and adopt by rule, course work or degrees that represent the best practices toward supplemental compensation goals, and:
  - Specifies that supplemental compensation shall be paid to qualifying full-time employees of a fire service provider.
  - Specifies that policy guidelines be adopted by rule, classifying the division as a fire service provider responsible for the payment of supplemental compensation to full-time firefighters employed by the division.
- Revises provisions relating to revocation of certification.
- Provides requirements with respect to application for certification.
- Revises provisions that require the division to make studies, investigations, inspections, and inquiries with respect to firefighter employee injuries, illnesses, safety-based complaints, or line-of-duty deaths in firefighter employee places of employment.
- Authorizes the division to adopt by rule procedures for conducting inspections and inquiries of firefighter employers and further authorizes the division to enter the premises to investigate compliance; provides criminal penalties; requires firefighter employers to submit a plan for the correction of noncompliance issues to the division for approval in accordance with division rule; and provides the procedure if a plan is not submitted, does not provide corrective actions, is incomplete, or is not implemented.
- Provides for workplace safety committees and coordinators, including mandatory negotiations during collective bargaining; provides for compensation of the workplace safety committee; and authorizes the cancellation of an insurance plan due to noncompliance.
- Prescribes additional administrative penalties for firefighter employers for violation of, or refusal to comply with, part V of ch. 633, F.S., and provides for location of hearings.
- Clarifies requirements from which private firefighter employers are exempt.
- Requires reinspection after specified noncompliance.

- Removes provisions that exclude from employment for a specified period an applicant for employment with a fire department who has a prior felony conviction.
- Revises provisions relating to adjustments in payments of accidental death benefits for firefighters.
- Repeals the retrofit of existing nursing homes through the State Fire Marshal Nursing Home Fire Protection Loan Guarantee Program.
- Repeals the State Fire Marshal Scholarship Grant Program.
- Specifies that independent special fire control districts may levy non-ad valorem assessments for emergency medical services and emergency transport services, and provides that if a district levies a non-ad valorem assessment for emergency medical services or emergency transport services, that district must cease charging an ad valorem tax for that service.
- Recognizes that the provision of emergency medical services and emergency transport services constitutes a benefit to real property.
- Provides that a district can levy non-ad valorem assessments on lands within the district (current law has allowed theses assessments on "benefitted property") for the exercise of the Independent Special Fire Control District Act, and removes the current law that had required that these assessments must be based on the specific benefit accruing to the benefitted property.

If approved by the Governor, these provisions take effect July 1, 2013
Vote: Senate 37-0; House 117-0

Committee on Banking and Insurance

CS/SB 1770 — Property Insurance

by Appropriations Committee and Banking and Insurance Committee

The bill makes the following changes to the Florida Hurricane Catastrophe Fund, Citizens Property Insurance Corporation, and Public Adjusters:

Florida Hurricane Catastrophe Fund (CAT Fund):

- Renames the "Florida Hurricane Catastrophe Fund Finance Corporation" to the "State Board of Administration Finance Corporation."
- Extends the CAT Fund assessment exemption for medical malpractice until May 31, 2016.
- Repeals outdated language for the $10M additional coverage for specified insurers and the Temporary Emergency Options for Additional Coverage.
- Requires the CAT Fund submit to the Legislature and Financial Services Commission an annual Probable Maximum Loss (PML) report for the upcoming storm season.

Citizens Property Insurance Corporation (Citizens)

- Exempts Citizens from "exchange of business" restrictions to facilitate the operations of the clearinghouse.
- Adds a professional structural engineer to the Florida Commission on Hurricane Loss Projection Methodology.
- Reduces the maximum Citizens' policy limit from $2 million to $1 million and further reduces this amount by $100,000 a year for 3 years to $700,000. Allows for an exemption in certain counties in which the Office of Insurance Regulation (OIR) determines do not have a reasonable degree of competition.
- Prohibits Citizens from covering structures commencing construction after July 1, 2014, seaward of the coastal construction control line.
- Allows the Governor of Florida to appoint a consumer representative to the Citizens Board of Governors in addition to the current two appointments.
- Clarifies a private company's offer within 15 percent of Citizens' rate for a new policy and no greater than the current rate for a renewal makes the policy ineligible for coverage with Citizens.
- Requires that Citizens disclose potential surcharge and assessment liabilities with each renewal notice.
- Allows insurers who take policies out of Citizens to use Citizens' policy forms for 3 years without approval from the OIR to use the forms.
- Establishes an office of Inspector General at Citizens to be appointed by the Financial Services Commission.
- Requires Citizens to prepare an annual report on Citizens' loss ratio for non-catastrophic losses on a statewide and county basis.
- Subjects Citizens to the purchasing of commodities restrictions under s. 287.057, F.S.

- Establishes the Citizens clearinghouse by January 1, 2014.
- Requires the establishment of a process to divert commercial residential policies.
- Requires that companies participating in the clearinghouse must either appoint the agent of record or offer a limited servicing agreement.
- Requires that agents are to be paid Citizens commission or the company's standard commission, whichever is greater.
- Clarifies that the 45-day notice of nonrenewal applies to policies submitted to the clearinghouse.
- Provides that independent and captive agents are granted and must maintain ownership of records including policies placed in Citizens.
- Allows captive companies to approve their agents limiting servicing agreements with each participating company.
- Requires Citizens to submit to the Legislature and Financial Services Commission an annual PML report for the upcoming storm season.

Public Adjusters

- Prohibits a public adjuster from receiving compensation from any source over the statutory fee cap. Applies disciplinary provisions in current law to public adjusters who violate the statutory fee caps through any maneuver, shift, or device.
- Repeals the current provision that for any claim filed with Citizens, a public adjuster cannot charge more than 10 percent of the difference between Citizens' initial offer and the amount actually paid.
- Requires a public adjuster to meet or communicate with the insurer to try to settle. Prohibits a public adjuster from acquiring any interest in salvaged property, without the written consent of the policyholder.

If approved by the Governor, these provisions take effect July 1, 2013, except as otherwise provided in this act.
Vote: Senate 32-1; House 111-6

Committee on Banking and Insurance

CS/SB 1842 — Health Insurance

by Appropriations Committee and Banking and Insurance Committee

The bill makes changes to the Florida Insurance Code related to the requirements of the federal Patient Protection and Affordable Care Act (PPACA) that apply to health insurers and health insurance policies. PPACA preempts any state law that prevents the application of a provision of the PPACA. Each state may enforce the requirements of the PPACA, but if the U.S. Department of Health and Human Services (HHS) determines that a state has failed to substantially enforce any provisions, HHS must enforce those provisions.

The bill makes the following changes to the Florida Insurance Code:

- Provides that a provision of the Florida Insurance Code (Code) or rule adopted pursuant to the Code applies unless such provision or rule prevents the application of a provision of PPACA. This is substantially the same preemption provision that is included in PPACA.
- Authorizes the Office of Insurance Regulation (OIR) to assist HHS in enforcing the provisions of the PPACA by reviewing policy forms and performing market conduct examinations or investigations for compliance with PPACA. OIR must first notify the insurer of any noncompliance and then notify HHS if the insurer does not take corrective action.
- Authorizes the Division of Consumer Services within the Department of Financial Services (DFS) to respond to complaints by consumers relating to requirements of PPACA, by performing its current statutory responsibilities to prepare and disseminate information to consumers as it deems appropriate, provide direct assistance and advocacy to consumers, and require insurers to respond, in writing, to a complaint, and further authorizes the division to report apparent or potential violations to OIR and to HHS.
- Temporarily suspends, for 2014 and 2015, the requirement that health insurers and HMOs (insurers) obtain approval from OIR for nongrandfathered health plans which, generally, are plans under which an individual was insured on March 23, 2010, and for which rates must be filed with HHS. Insurers will still be required to file rates and rate changes for such plans with OIR prior to use, but such rates may be used without OIR approval. For this 2-year period, the rates for nongrandfathered plans would be exempt from all rating requirements. These rating law changes are repealed on March 1, 2015. Under PPACA, insurers must file rate changes with HHS for nongrandfathered health plans, subject to review and determination of whether the rate increase is unreasonable. Grandfathered health plans are not subject to PPACA rate filing requirements and remain subject to the current Florida law requirements for filing rates for approval with OIR.
- Requires insurers to provide a notice to individual and small group policyholders of nongrandfathered health plans that describes or illustrates the estimated impact of PPACA on monthly premiums. This notice is required one time, when the policy is issued or renewed on or after January 1, 2014. The notice must be in a format established by rule by the Financial Services Commission. The OIR and DFS must develop a

summary of the estimated impact of PPACA on monthly premiums as contained in the notices, which must be available on their respective websites by October 1, 2013.

- Requires individuals acting as a "navigator" under PPACA to be registered with DFS, beginning August 1, 2013. Under PPACA, beginning on October 1, 2013, individuals and small businesses will be able to purchase private health insurance through Affordable Insurance Exchanges (Exchanges). Exchanges must certify qualified health plans (QHPs) offered by insurers through the Exchange. PPACA directs Exchanges to award grants to "navigators" that will facilitate enrollment in QHPs and exercise certain other duties.
- To be registered as a navigator under the bill, an individual must certify completion of federally-required training, submit fingerprints for a criminal background check, and pay a $50 application fee (currently, there is a $50.30 fingerprint processing fee for agents, so the total cost for a navigator would be $100.30). Certain crimes would either permanently bar an individual from registration or disqualify an applicant for specified periods. A navigator will be prohibited from:
  - Recommending the purchase of a particular health plan or represent that one health plan is preferable over any other;
  - Recommending or assisting with the cancellation of insurance coverage purchased outside the Exchange;
  - Receiving compensation or anything of value from an insurer, health plan, business, or consumer in connection with performing activities as a navigator, other than from the Exchange or an entity or individual who has received a navigator grant under the PPACA.
- Specifies grounds for suspension or revocation of registration and authorizes DFS to impose an administrative fine in lieu of, or in addition to suspension or revocation. Any person who acts as a navigator without registration is subject to an administrative penalty not to exceed $1,500.
- Makes the following changes that allow or require insurers to take certain actions that would preserve the status of grandfathered health plans which, in general, are plans under which an individual was insured on March 23, 2010, and which are exempt from many of the requirements of PPACA:
  - If a policy form covers both grandfathered health plans and nongrandfathered health plans, the bill allows an insurer to non-renew coverage only for all of the nongrandfathered health plans, subject to certain conditions.
  - Requires that the claims experience for grandfathered health plans be separated from nongrandfathered health plans for rating purposes, as also required by PPACA.
  - Allows an insurer to discontinue a policy form that does not comply with PPACA without being subject to the current prohibition on selling a new, similar policy form after a policy form is discontinued.
- Provides two different definitions of "small employer" – one for grandfathered health plans, which is the current law definition, and one for nongrandfathered health plans, which is the same as the federal definition used for PPACA (but capped at 50 employees, as allowed by PPACA). For nongrandfathered health plans, any state law that applies to small group coverage will apply to coverage for a small employer as defined under

PPACA and will no longer apply to an employer who is not a small employer under the federal definition.

- Requires the dissolution of the Florida Comprehensive Health Association (FCHA), which is the state's high risk pool for persons unable to obtain health insurance, by September 1, 2015. Coverage for current FCHA policyholders will be terminated by June 30, 2014. The FCHA is required to assist each policyholder in obtaining health insurance coverage, which is available to all persons on a guaranteed-issue basis under PPACA beginning October 1, 2013, with coverage beginning January 1, 2014.
- Specifies that health insurers and HMOs may nonrenew individual conversion policies if the individual is eligible for other similar coverage (which is available under PPACA).
- Repeals the statute that establishes the Florida Health Insurance Plan, which has never been implemented.

If approved by the Governor, these provisions take effect upon becoming law.
Vote: Senate 25-6; House 78-36

Committee on Banking and Insurance

SB 1850 — Public Records/Citizens Property Insurance Corporation Clearinghouse

by Banking and Insurance Committee

The bill exempts from public record proprietary business information which is owned or controlled by an insurer participating in the Citizens clearinghouse program created in CS/SB 1770, and:

- Is identified by the insurer as proprietary business information and is intended to be and is treated by the insurer as private in that the disclosure of the information would cause harm to the insurer, an individual, or the company's business operations and has not been disclosed unless disclosed pursuant to a statutory requirement, an order of a court or administrative body, or a private agreement that provides that the information will not be released to the public;
- Is not otherwise readily ascertainable or publicly available by proper means by other persons from another source in the same configuration as provided to the clearinghouse; and,
- Includes, but is not limited to:
  - Trade secrets.
  - Information relating to competitive interests, the disclosure of which would impair the competitive business of the provider of the information.

Proprietary business information may be found in underwriting criteria or instructions which are used to identify and select risks through the program for an offer of coverage and are shared with the clearinghouse to facilitate the shopping of risks with the insurer.

The clearinghouse may disclose confidential and exempt proprietary business information:

- If the insurer to which it pertains gives prior written consent;
- Pursuant to a court order; or
- To another state agency in this or another state or to a federal agency if the recipient agrees in writing to maintain the confidential and exempt status of the document, material, or other information and has verified in writing its legal authority to maintain such confidentiality.

The bill is subject to the Open Government Sunset Review Act in accordance with s. 119.15, F.S., and shall stand repealed on October 2, 2018, unless reviewed and saved from repeal through reenactment by the Legislature.

If approved by the Governor, these provisions take effect upon becoming law, if CS/SB 1770 is approved, and shall take effect July 1, 2013.
Vote: Senate 36-2; House 109-5