CHAPTER 2015-135

Committee Substitute for Committee Substitute for Committee Substitute for House Bill No. 165

An act relating to property and casualty insurance; amending s. 627.062, F.S.; restricting to certain property rate filings a requirement that the chief executive officer or chief financial officer and chief actuary of a property insurer certify the information contained in a rate filing; amending s. 627.0628, F.S.; requiring an insurer to employ in certain rate filings actuarial methods, principles, standards, models, or output ranges found by the Florida Commission on Hurricane Loss Projection Methodology to be accurate or reliable in determining probable maximum loss levels; authorizing an insurer to employ a model in a rate filing until 120 days after the expiration of the commission's acceptance of that model; prohibiting insurers from modifying or adjusting the model after the commission finds the model to be accurate or reliable in determining probable maximum loss levels; amending s. 627.0645, F.S.; exempting commercial nonresidential multiperil insurance from annual base rate filing; amending s. 627.3518, F.S.; conforming a cross-reference; amending s. 627.4133, F.S.; increasing the amount of prior notice required with respect to the nonrenewal, cancellation, or termination of certain insurance policies; deleting certain provisions that require extended periods of prior notice with respect to the nonrenewal, cancellation, or termination of certain insurance policies; prohibiting the cancellation of certain policies that have been in effect for a specified amount of time except under certain circumstances; amending s. 627.7074, F.S.; revising notification requirements for participation in the neutral evaluation program; amending s. 627.736, F.S.; revising the period for applicability of certain Medicare fee schedules or payment limitations; exempting certain federally certified entities from the requirement to be licensed in order to receive reimbursement under the Florida Motor Vehicle No-Fault Law; amending s. 627.744, F.S.; revising preinsurance inspection requirements for private passenger motor vehicles; amending s. 631.65, F.S.; authorizing, rather than prohibiting, an advertisement or a solicitation to use the existence of the Florida Insurance Guaranty Association to sell, solicit, or induce the purchase of certain insurance if the advertisement or solicitation explains specified coverage limits; providing an effective date.

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

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

627.062 Rate standards.—

(8)(a) The chief executive officer or chief financial officer of a property insurer and the chief actuary of a property insurer must certify under oath and subject to the penalty of perjury, on a form approved by the commission,

the following information, which must accompany a property rate filing subject to paragraph (2)(a):

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

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

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

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

Section 2. Paragraph (d) of subsection (3) of section 627.0628, Florida Statutes, is amended to read:

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

(3) ADOPTION AND EFFECT OF STANDARDS AND GUIDELINES.

(d) With respect to a rate filing under s. 627.062, an insurer shall employ and may not modify or adjust actuarial methods, principles, standards, models, or output ranges found by the commission to be accurate or reliable in determining hurricane loss factors and probable maximum loss levels for use in a rate filing under s. 627.062. An insurer may ~~shall~~ employ a model in a rate filing until 120 days after the expiration of the commission's acceptance of that model and may not modify or adjust models found by the commission to be accurate or reliable in determining probable maximum loss levels ~~pursuant to paragraph (b) with respect to a rate filing under s. 627.062 made more than 60 days after the commission has made such findings~~. This paragraph does not prohibit an insurer from using a straight average of model results or output ranges for the purposes of a rate filing for personal lines residential flood insurance coverage under s. 627.062.

Section 3. Paragraph (b) of subsection (1) of section 627.0645, Florida Statutes, is amended to read:

627.0645 Annual filings.—

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

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

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

Section 4. Subsection (9) of section 627.3518, Florida Statutes, is amended to read:

627.3518 Citizens Property Insurance Corporation policyholder eligibility clearinghouse program.—The purpose of this section is to provide a framework for the corporation to implement a clearinghouse program by January 1, 2014.

(9) The 45-day notice of nonrenewal requirement set forth in s. 627.4133(2)(b)5. ~~627.4133(2)(b)5.b.~~ applies when a policy is nonrenewed by the corporation because the risk has received an offer of coverage pursuant to this section which renders the risk ineligible for coverage by the corporation.

Section 5. Paragraph (b) of subsection (2) of section 627.4133, Florida Statutes, is amended to read:

627.4133 Notice of cancellation, nonrenewal, or renewal premium.—

(2) With respect to any personal lines or commercial residential property insurance policy, including, but not limited to, any homeowner, mobile home owner, farmowner, condominium association, condominium unit owner, apartment building, or other policy covering a residential structure or its contents:

(b) The insurer shall give the first-named insured written notice of nonrenewal, cancellation, or termination at least 120 ~~100~~ days before the effective date of the nonrenewal, cancellation, or termination. ~~However, the insurer shall give at least 100 days' written notice, or written notice by June 1, whichever is earlier, for any nonrenewal, cancellation, or termination that would be effective between June 1 and November 30.~~ The notice must include the reason for the nonrenewal, cancellation, or termination, except that:

~~1. The insurer shall give the first-named insured written notice of nonrenewal, cancellation, or termination at least 120 days before the effective date of the nonrenewal, cancellation, or termination for a first-named insured whose residential structure has been insured by that insurer or an affiliated insurer for at least 5 years before the date of the written notice.~~

1.~~2.~~ If cancellation is for nonpayment of premium, at least 10 days' written notice of cancellation accompanied by the reason therefor must be given. As used in this subparagraph, the term "nonpayment of premium"

means failure of the named insured to discharge when due her or his obligations for paying the premium on a policy or an installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under a premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. The term also means the failure of a financial institution to honor an insurance applicant's check after delivery to a licensed agent for payment of a premium even if the agent has previously delivered or transferred the premium to the insurer. If a dishonored check represents the initial premium payment, the contract and all contractual obligations are void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail. If the contract is void, any premium received by the insurer from a third party must be refunded to that party in full.

2.~~3.~~ If cancellation or termination occurs during the first 90 days the insurance is in force and the insurance is canceled or terminated for reasons other than nonpayment of premium, at least 20 days' written notice of cancellation or termination accompanied by the reason therefor must be given unless there has been a material misstatement or misrepresentation or a failure to comply with the underwriting requirements established by the insurer.

3. After the policy has been in effect for 90 days, the policy may not be canceled by the insurer unless there has been a material misstatement; a nonpayment of premium; a failure to comply, within 90 days after the date of effectuation of coverage, with underwriting requirements established by the insurer before the date of effectuation of coverage; or a substantial change in the risk covered by the policy or unless the cancellation is for all insureds under such policies for a given class of insureds. This subparagraph does not apply to individually rated risks that have a policy term of less than 90 days.

4. After a policy or contract has been in effect for more than 90 days, the insurer may not cancel or terminate the policy or contract based on credit information available in public records.

~~5. The requirement for providing written notice by June 1 of any nonrenewal that would be effective between June 1 and November 30 does not apply to the following situations, but the insurer remains subject to the requirement to provide such notice at least 100 days before the effective date of nonrenewal:~~

~~a. A policy that is nonrenewed due to a revision in the coverage for sinkhole losses and catastrophic ground cover collapse pursuant to s. 627.706.~~

5.~~b.~~ A policy that is nonrenewed by Citizens Property Insurance Corporation, pursuant to s. 627.351(6), for a policy that has been assumed by an authorized insurer offering replacement coverage to the policyholder is

exempt from the notice requirements of paragraph (a) and this paragraph. In such cases, the corporation must give the named insured written notice of nonrenewal at least 45 days before the effective date of the nonrenewal.

~~After the policy has been in effect for 90 days, the policy may not be canceled by the insurer unless there has been a material misstatement, a nonpayment of premium, a failure to comply with underwriting requirements established by the insurer within 90 days after the date of effectuation of coverage, a substantial change in the risk covered by the policy, or the cancellation is for all insureds under such policies for a given class of insureds. This paragraph does not apply to individually rated risks that have a policy term of less than 90 days.~~

6. Notwithstanding any other provision of law, an insurer may cancel or nonrenew a property insurance policy after at least 45 days' notice if the office finds that the early cancellation of some or all of the insurer's policies is necessary to protect the best interests of the public or policyholders and the office approves the insurer's plan for early cancellation or nonrenewal of some or all of its policies. The office may base such finding upon the financial condition of the insurer, lack of adequate reinsurance coverage for hurricane risk, or other relevant factors. The office may condition its finding on the consent of the insurer to be placed under administrative supervision pursuant to s. 624.81 or to the appointment of a receiver under chapter 631.

7. A policy covering both a home and a motor vehicle may be nonrenewed for any reason applicable to the property or motor vehicle insurance after providing 90 days' notice.

Section 6. Subsection (3) of section 627.7074, Florida Statutes, is amended to read:

627.7074 Alternative procedure for resolution of disputed sinkhole insurance claims.—

(3) <u>If there is coverage available under the policy and the claim was submitted within the timeframe provided in s. 627.706(5),</u> following the receipt of the report provided under s. 627.7073 or the denial of a claim for a sinkhole loss, the insurer shall notify the policyholder of his or her right to participate in the neutral evaluation program under this section. Neutral evaluation supersedes the alternative dispute resolution process under s. 627.7015 but does not invalidate the appraisal clause of the insurance policy. The insurer shall provide to the policyholder the consumer information pamphlet prepared by the department pursuant to subsection (1) electronically or by United States mail.

Section 7. Paragraphs (a) and (h) of subsection (5) of section 627.736, Florida Statutes, are amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a) A physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. However, such a charge may not exceed the amount the person or institution customarily charges for like services or supplies. In determining whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, reimbursement levels in the community and various federal and state medical fee schedules applicable to motor vehicle and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

1. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002 provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under:

(I) The participating physicians fee schedule of Medicare Part B, except as provided in sub-sub-subparagraphs (II) and (III).

(II) Medicare Part B, in the case of services, supplies, and care provided by ambulatory surgical centers and clinical laboratories.

(III) The Durable Medical Equipment Prosthetics/Orthotics and Supplies fee schedule of Medicare Part B, in the case of durable medical equipment.

However, if such services, supplies, or care is not reimbursable under Medicare Part B, as provided in this sub-subparagraph, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the service year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee schedule or payment limitation applies to services, supplies, or care rendered during ~~throughout the remainder of~~ that service year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B. For purposes of this subparagraph, the term "service year" means the period from March 1 through the end of February of the following year.

3. Subparagraph 1. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 1. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider is entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes. However, subparagraph 1. does not prohibit an insurer from using the Medicare coding policies and payment methodologies of the federal Centers for Medicare and Medicaid Services, including applicable modifiers, to determine the appropriate amount of reimbursement for medical services, supplies, or care if the coding policy or payment methodology does not constitute a utilization limit.

4. If an insurer limits payment as authorized by subparagraph 1., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

5. ~~Effective July 1, 2012,~~ An insurer may limit payment as authorized by this paragraph only if the insurance policy includes a notice at the time of issuance or renewal that the insurer may limit payment pursuant to the schedule of charges specified in this paragraph. A policy form approved by the office satisfies this requirement. If a provider submits a charge for an amount less than the amount allowed under subparagraph 1., the insurer may pay the amount of the charge submitted.

(h) As provided in s. 400.9905, an entity excluded from the definition of a clinic shall be deemed a clinic and must be licensed under part X of chapter 400 in order to receive reimbursement under ss. 627.730-627.7405. However, this licensing requirement does not apply to:

1. An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician;

2. An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

3. An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician;

4. A hospital or ambulatory surgical center licensed under chapter 395;

5. An entity that wholly owns or is wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395; ~~or~~

6. An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows; or

7. An entity that is certified under 42 C.F.R. part 485, subpart H.

Section 8. Paragraphs (a) and (b) of subsection (2) of section 627.744, Florida Statutes, are amended to read:

627.744 Required preinsurance inspection of private passenger motor vehicles.—

(2) This section does not apply:

(a) To a policy for a policyholder who has been insured for 2 years or longer, without interruption, under a private passenger motor vehicle policy that ~~which~~ provides physical damage coverage for any vehicle~~,~~ if the agent of the insurer verifies the previous coverage.

(b) To a new, unused motor vehicle purchased or leased from a licensed motor vehicle dealer or leasing company.~~, if~~ The insurer may require ~~is provided with~~:

1. A bill of sale, ~~or~~ buyer's order, or lease agreement that ~~which~~ contains a full description of the motor vehicle~~, including all options and accessories~~; or

2. A copy of the title or registration that ~~which~~ establishes transfer of ownership from the dealer or leasing company to the customer and a copy of the window sticker ~~or the dealer invoice showing the itemized options and equipment and the total retail price of the vehicle~~.

For the purposes of this paragraph, the physical damage coverage on the motor vehicle may not be suspended during the term of the policy due to the applicant's failure to provide or the insurer's option not to require the ~~required~~ documents. However, if the insurer requires a document under this paragraph at the time the policy is issued, payment of a claim may be ~~is~~ conditioned upon the receipt by the insurer of the required documents, and no physical damage loss occurring after the effective date of the coverage may be ~~is~~ payable until the documents are provided to the insurer.

Section 9. Section 631.65, Florida Statutes, is amended to read:

631.65 ~~Prohibited~~ Advertisement or solicitation.—An ~~No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any~~ advertisement or a solicitation that~~, announcement, or statement which~~ uses the existence of the ~~insurance guaranty~~ association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered under this part must explain the coverage limits of the association set forth in s. 631.57(1) which apply to the type of insurance described in the advertisement or solicitation. ~~However, this section does not prohibit a duly licensed insurance agent from explaining the existence or function of the insurance guaranty association to policyholders, prospects, or applicants for coverage.~~

Section 10. This act shall take effect July 1, 2015.

Approved by the Governor June 11, 2015.

Filed in Office Secretary of State June 11, 2015.