Tab 1	**SB 98** by **Steube**; (Identical to H 00199) Health Insurer Authorization

Tab 2	**SB 220** by **Passidomo**; (Identical to H 00271) Bankruptcy Matters in Foreclosure Proceedings

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Tuesday, November 7, 2017
TIME: 10:00 a.m.—12:00 noon
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Flores, Chair; Senator Steube, Vice Chair; Senators Bracy, Bradley, Braynon, Broxson, Gainer, Garcia, Grimsley, Taddeo, and Thurston

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 98** Steube (Identical H 199)	Health Insurer Authorization; Prohibiting prior authorization forms from requiring certain information; requiring health insurers and pharmacy benefits managers on behalf of health insurers to provide certain information relating to prior authorization by specified means; requiring health insurers to publish on their websites and provide to insureds in writing a procedure for insureds and health care providers to request protocol exceptions, etc. BI 11/07/2017 Favorable JU RC	Favorable Yeas 10 Nays 0
2	**SB 220** Passidomo (Identical H 271)	Bankruptcy Matters in Foreclosure Proceedings; Authorizing lienholders to use certain documents as an admission in an action to foreclose a mortgage; providing that submission of certain documents in a foreclosure action creates a rebuttable presumption that the defendant has waived any defenses to the foreclosure; requiring a court to take judicial notice of orders entered in bankruptcy cases under certain circumstances, etc. BI 11/07/2017 Favorable JU RC	Favorable Yeas 9 Nays 0
3	Managed Repair Discussion		Discussed
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 98
INTRODUCER:	Senator Steube
SUBJECT:	Health Insurer Authorization
DATE:	November 6, 2017
REVISED:	11/07/17

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

I. Summary:

SB 98 revises provisions of the Insurance Code relating to prior authorization and step therapy or fail-first protocols. The bill creates an expedited, standard process for the approval or denial of prior authorizations and protocol exceptions, which provides greater transparency for consumers and providers regarding the policies and procedures of health insurers.

Under a prior authorization process, a health care provider is required to seek approval from an insurer before a patient may receive a health care service under the plan. Step therapy or fail-first protocols for medical treatment or prescription drugs coverage require an insured or enrollee to try a certain drug or treatment before receiving coverage for another drug or medical treatment. However, timely access to appropriate health care can be critical for individuals who have chronic conditions that may cause death, disability, or serious discomfort.

The bill:

- Requires a health insurer (which means a health insurer, health maintenance organization, or Medicaid managed care plan), or pharmacy benefit manager (PBM) on behalf of a health insurer to authorize or deny a prior authorization request or a protocol exception request or appeal of a denial in nonurgent care situation within 72 hours after receipt of a completed prior authorization form or protocol exception request. In urgent circumstances, a health insurer must authorize or deny a request within 24 hours.
- Provides greater transparency for consumers by requiring health insurers or PBMs to provide public access to current prior authorization requirements, restrictions, and forms on their websites and, upon request, in written or electronic form. If a health insurer or PBM intends to amend or implement a new prior authorization requirement or restriction, the entity must update the website 60 days before the effective date of the new requirement or restriction. Notification of the change must be provided to all insureds or enrollees using the affected service and to all contract providers who provide the affected services at least 60 days before the effective date.

- Requires a health insurer to grant a protocol exception request under certain conditions.
- Provides that if the health insurer authorizes the protocol exception request, the health insurer must specify the approved medical procedure, course of treatment, or prescription drug benefits.
- Requires that if the health insurer denies the protocol exception request, the health insurer must provide specified information, including procedures on appealing a denial.

The bill will have an operational and fiscal impact on the Florida Medicaid program, but the impact to Medicaid is indeterminate. The Agency for Health Care Administration will need to amend the Statewide Medicaid Managed Care contracts to comply with the revised statute, which will affect the business and clinical operations of the Medicaid managed care plans. The bill will likely increase Medicaid costs as the health plans will likely have to deploy additional staffing resources to respond to the prior authorization override inquiries and expedited timeframes as required in the bill. The additional staffing resources will need to be accounted for in the administrative expenses included in the capitation rates, but this cannot be determined thus making the fiscal impact to Florida Medicaid indeterminate.

The State Group Insurance program indicates that the bill would have a fiscal impact on the program. The fully insured health maintenance organization (HMO) vendor, Capital Health Plan (CHP), states that the bill would negatively affect it, specifically; the initial estimated fiscal impact for CHP would be $256,000 annually, based upon the need to employ an additional four medical staff and three support staff employees. The pharmacy benefit, CVS Caremark, indicated that the bill would adversely impact it, and any fiscal impacts to State Group Insurance would be the result of an increase in approvals of claims. The bill would not impact the self-insured plans.

There is no fiscal impact on the Office of Insurance Regulation.

II. Present Situation:

Regulation of Insurers and Health Maintenance Organizations in Florida

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[1] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[2] As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[3]

The Florida Insurance Code requires health insurers and HMOs to provide an outline of coverage or other information describing the benefits, coverages, and limitations of a policy or contract. This may include an outline of coverage describing the principal exclusions and limitations of

[1] Section 20.121(3)(a), F.S.
[2] Section 641.21(1), F.S.
[3] Section 641.495, F.S.

the policy.[4] Further, each contract, certificate, or member handbook of an HMO must delineate the services for which a subscriber is entitled and any limitations under the contract.[5]

Section 627.4234, F.S., requires a health insurance policy or health care services plan, which provides medical, hospital, or surgical expense coverage delivered or issued for delivery in this state to contain one or more of the following procedures or provisions to contain health insurance costs or cost increases:

- Coinsurance.
- Deductible amounts.
- Utilization review.
- Audits of provider bills to verify that services and supplies billed were furnished and that proper charges were made.
- Scheduled benefits.
- Benefits for preadmission testing.
- Any lawful measure or combination of measures for which the insurer provides to the office information demonstrating that the measure or combination of measures is reasonably expected to contain health insurance costs or cost increases.

Pursuant to s. 627.42392, F.S., any health insurer (health insurer, HMO, Medicaid managed care plan) or pharmacy benefit manager, on behalf of the health insurer, that does not use an online prior authorization form must use a standardized form adopted by the Financial Services Commission to obtain a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form must include all clinical documentation necessary for the health insurer to make a decision.

Florida's Statewide Medicaid Managed Care[6]

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, the Agency for Health Care Administration (agency) oversees the Medicaid program.[7] The Statewide Medicaid Managed Care (SMMC) program is comprised of the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) managed care program. The agency contracts with managed care plans to provide services to eligible enrollees.[8]

Managed Care Covered Services

The benefit package offered by the MMA plans is comprehensive and covers all Medicaid state plan benefits (with very limited exceptions). This includes all medically necessary services for children. Most Florida Medicaid enrollees who are eligible for the full array of Florida Medicaid benefits are enrolled in an MMA plan. The agency maintains coverage policies for most Florida

[4] Section 627.642, F.S.
[5] Section 641.31(4), F.S.
[6] Agency for Health Care Administration, *2018 Legislative Bill Analysis of SB 98* (Oct. 31, 2017) (on file with the Senate Committee on Banking and Insurance).
[7] Part III of ch. 409, F.S., governs the Medicaid program.
[8] A managed care plan that is eligible to provide services under the SMMC program must have a contract with the agency to provide services under the Medicaid program; be a health insurer, an exclusive provider organization or a HMO authorized under ch. 624, 627, or 641, F.S., respectively, or a provider service network authorized under s. 409.912(2), F.S., or an accountable care organization authorized under federal law. (s. 409.962, F.S.)

Medicaid services, which are incorporated by reference into Rule 59G-4, F.A.C. Florida Medicaid managed care plans cannot be more restrictive than these policies or the Florida Medicaid state plan (which is approved by the federal Centers for Medicare and Medicaid Services) in providing services to their enrollees.

Section 409.91195, F.S., establishes the Pharmaceutical and Therapeutics (P&T) committee within the agency for the development of a Florida Medicaid preferred drug list (PDL). The P&T committee meets quarterly, reviews all drug classes included in the formulary at least every 12 months, and may recommend additions to and deletions from the agency's Medicaid PDL, such that the PDL provides for medically appropriate drug therapies for Florida Medicaid recipients and an array of choices for prescribers within each therapeutic class. The agency also manages the federally required Medicaid Drug Utilization Board, which meets quarterly, and develops and reviews clinical prior authorization criteria, including step-therapy protocols for drugs that are not on the Medicaid PDL.

Florida Medicaid managed care plans serving MMA enrollees are required to provide all prescription drugs listed on the agency's PDL and otherwise covered by Medicaid.[9] As such, the Florida Medicaid managed care plans have not implemented their own plan-specific formulary or PDL. The Florida Medicaid managed care plan's prior authorization criteria and protocols related to prescription drugs cannot be more restrictive than the criteria established by the agency.

Prior Authorization Requirements

Florida Medicaid managed care plans may implement service authorization and utilization management requirements for the services they provide under the SMMC program. However, Florida Medicaid managed care plans are required to ensure that service authorization decisions are based on objective evidenced-based criteria; utilization management procedures are applied consistently; and all decisions to deny or limit a requested service are made by health care providers who have the appropriate clinical expertise in treating the enrollee's condition. The Florida Medicaid managed care plans are also required to adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; consider the needs of the enrollees; are adopted in consultation with providers; and are reviewed and updated periodically, as appropriate.[10]

Florida Medicaid managed care plans must establish and maintain a utilization management system to monitor utilization of services, including an automated service authorization system for denials, service limitations, and reductions of authorization. Section 627.42392, F.S., requires the use of a standard prior authorization form by health insurers. A health insurer that does not provide an electronic prior authorization process for use by its providers is required to use the prior authorization form adopted by the Financial Services Commission for authorization of procedures, treatments, or prescription drugs. Currently, Medicaid managed care plans are

[9] See Agency for Health Care Administration Pharmacy Policy available at: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/pharmacy_policy/index.shtml (last viewed Nov. 5, 2017).
[10] These guidelines are consistent with requirements found in federal and state regulations (See 42 CFR s. 438.236(b)). All service authorization decisions made by the managed care plans must be consistent with the State's Medicaid medical necessity definition (Rule 59G-1.010, F.A.C.).

required by contract to have electronic authorization processes and are therefore exempt from this provision.

The SMMC contract requires managed care plans to authorize or deny a standard request for prior authorization for services other than prescribed drugs within 7 days and authorize or deny an expedited request within 48 hours after receiving the request. Within 24 hours after receipt of a request, a managed care plan must respond (deny, approve, or request additional information) to a request for prior authorization for prescription drugs. The timeframe for standard authorization decisions can be extended up to 7 additional days if the enrollee or the provider requests an extension or the managed care plan justifies the need for additional information and describes how the extension is in the enrollee's interest.

Enrollee Materials and Services

Managed care plans are contractually required to notify enrollees via the enrollee handbook of any procedures for obtaining required services and authorization requirements, including any services available without prior authorization. All enrollee communications, including written materials, spoken scripts, and websites, must be at or near the fourth grade reading level. Managed care plans are required by contract to issue a provider handbook to all providers that includes prior authorization and referral procedures, including required forms. Managed care plans are required to keep all provider handbooks and bulletins up to date and in compliance with state and federal laws. The managed care plans must notify its enrollees in writing of any changes to covered services or service authorization protocols at least 30 days in advance of the change.

The managed care plan must send a written notice of adverse benefit determination to the enrollee to inform the enrollee about a decision to deny, reduce, suspend, or terminate a requested service and provide directions on how the enrollee may ask for a plan appeal to dispute the managed care plan's adverse benefit determination. The enrollee has 60 days after the plan's adverse benefit determination to ask for a plan appeal. For decisions that are appealed, the managed care plan must have a second health care professional who was neither involved in any previous level of review or decision-making, nor a subordinate of any such individual. The managed care plan then has 30 days from the date of the enrollee's request to make a final decision. The managed care plan has 72 hours to respond to the enrollee or his or her authorized representative's request for an expedited plan appeal. The enrollee must complete the plan appeal process before asking for a Medicaid fair hearing.

Florida State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group insurance program by providing employee benefits such as health, life, dental, and vision insurance products under a cafeteria plan consistent with s. 125, Internal Revenue Code. To administer the state group health insurance program, the DMS contracts with third party administrators, HMOs, and a PBM for the state employees' prescription drug program pursuant to s. 110.12315, F.S.

Contractually, health plans and contracted third party administrators are required to review urgent or emergency prior authorization requests within 24 hours after receipt and within

14 calendar days after initial receipt for routine requests. Current industry standards for utilization review change notices to plan participants or enrollees is 30 days.[11]

Federal Patient Protection and Affordable Care Act

Health Insurance Reforms

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[12] The PPACA requires health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA also mandates required essential health benefits[13] and other provisions.

The PPACA requires insurers and HMOs that offer qualified health plans (QHPs) to provide ten categories of essential health benefits (EHB), which includes prescription drugs.[14] In Florida, the federal Health Insurance Marketplace must certify such plans of an insurer or HMO as meeting the EHB and other requirements.[15] The federal deadline for insurers and HMOs to submit 2018 annual rates and forms to the Florida Office of Insurance Regulation was May 3, 2017.[16,17] Recently, the U.S. Department of Health and Human Services (HHS) proposed federal regulations that included provisions to provide states with additional flexibility in the definition of EHBs for 2019 and 2020 and increase affordability of health insurance in the individual and small group markets.[18]

Prescription Drug Coverage

For purposes of complying with the federal EHB for prescription drugs, plans must include in their formulary drug list the greater of one drug for each U.S. Pharmacopeia (USP) category and

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[11] Department of Management Services, *2018 Legislative Bill Analysis SB 98* (Oct. 31, 2017) (on file with the Senate Banking and Insurance Committee).
[12] The Patient Protection and Affordable Care Act (Pub. L. No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010.
[13] 42 U.S.C. s.18022.
[14] See Center for Consumer Information & Insurance Oversight, *Information on Essential Health Benefits (EHB) Benchmark Plans* https://www.cms.gov/cciio/resources/data-resources/ehb.html (last viewed Nov. 5, 2017) for Florida's benchmark plan.
[15] Center for Consumer Information & Insurance Oversight, *Qualified Health Plans,* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html (last viewed Nov. 5, 2017).
[16] Office of Insurance Regulation, *Guidance to Insurers*, available at http://www.floir.com/sitedocuments/PPACANoticetoIndustry201802032017.pdf (last viewed Nov. 5, 2017).
[17] President Trump, Executive Order 13765, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal*, https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and (Jan. 20, 2017). President Trump issued an executive order indicating that it is the intent of his administration to seek the prompt repeal of PPACA. (last viewed: Nov. 5, 2017).
[18] *See* Proposed Rule, 82 FR 51052 (Nov. 2, 2017). The U.S. Department of Health and Human Services is soliciting comments on different applications of the state mandate policy to the proposed policy for EHB benchmark plan selections that would increase state flexibility, while also being cost effective for states, consumers, and the federal government. For plan years further in the future, the HHS is considering establishing a Federal default definition of EHBs that would better align medical risk in insurance products by balancing costs to the scope of benefits. Available at https://www.federalregister.gov/documents/2017/11/02/2017-23599/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019 (last viewed Nov. 5, 2017).

class; or the same number of drugs in each USP category and class as the state's EHB benchmark plan. Plans must have a Pharmacy and Therapeutics Committee design formularies using scientific evidence that will include consideration of safety and efficacy, cover a range of drugs in a broad distribution of therapeutic categories and classes, and provide access to drugs that are included in broadly accepted treatment guidelines. The PPACA also requires plans to implement an internal appeals and independent external review process if an insured is denied coverage of a drug on the formulary.[19]

Plans are required to publish a current and complete list of all covered drugs on its formulary drug list, including any tiered structure and any restrictions on the way a drug can be obtained, in a manner that is easily accessible to insureds, prospective insureds, the state, and the public.[20] Restrictions include prior authorization, step therapy, quantity limits and access restrictions.[21]

Cost Containment Measures Used by Insurers and HMOs

Insurers use many cost containment and utilization review strategies to manage medical and drug spending and patient safety. For example, plans may place utilization management requirements on the use of certain medical treatments or drugs on their formulary. Under prior authorization, a health care provider is required to seek approval from an insurer before a patient may receive a specified diagnostic or therapeutic treatment or specified prescription drugs under a plan. In some cases, plans require an insured to use a step therapy protocol for drugs or a medical treatment, which requires the insured to try one drug or medical procedure first to treat the medical condition before the insurer or HMO will cover another drug or procedure for that condition.

III. Effect of Proposed Changes:

Section 1 revises s. 627.42392, F.S., relating to prior authorization by a health insurer. A health insurer is defined as an authorized insurer offering major medical or similar comprehensive coverage, a Medicaid managed care plan, or an HMO. The section defines the term, "urgent care situation," which has the same meaning as in s. 627.42393, F.S. (see section 2, below).

A health insurer or a PBM on behalf of a health insurer is required to provide current prior authorization requirements, restrictions, and forms on a publicly accessible website and in written or electronic format upon request. The requirements must be described in clear and easily understandable language. Further, the bill requires any clinical criteria to be described in language easily understandable by a provider.

If a health insurer or a PBM on behalf of a health insurer intends to amend or implement new prior authorization requirements or restrictions, the health insurer or PBM must:

- Ensure that the new or amended requirements or restrictions are available on their website at least 60 days before the effective date of the changes.

[19] 45 C.F.R. s. 147.136.
[20] 45 C.F.R. s. 156.122(d).
[21] According to Centers for MS, this formulary drug list website link should be the same direct formulary drug list link for obtaining information on prescription drug coverage in the Summary of Benefits Coverage, in accordance with 45 CFR s. 147.200(a)(2).

- Provide notice to policyholders and providers who are affected by the changes at least 60 days before the effective date. Notice may be delivered electronically or by other methods mutually agreed upon by the insured or provider.

These notice requirements do not apply to expansion of coverage.

Health insurers or PBMs on behalf of health insurers must approve or deny prior authorization requests in urgent and nonurgent care circumstances within 24 hours and 72 hours, respectively, after receipt of the prior authorization form. Notice must be given to the patient and the treating provider of the patient.

Section 2 creates s. 627.42393, F.S., relating to step therapy or fail-first protocols. The bill defines the following terms:

- "Fail-first protocol," is a written protocol that specifies the order in which a certain medical procedure, prescription drugs or course of treatment must be used to treat an insured's condition.
- "Health insurer" has the same meaning as provided in s. 627.42392, F.S. (see section 1, above).
- "Preceding prescription drug or medical treatment," is a medical procedure, course of treatment, or prescription drug that must be used pursuant to a health insurer's fail first protocol as a condition of coverage under a health insurance policy or HMO contract to treat an insured's condition.
- "Protocol exception" is a determination by a health insurer that a fail first protocol is not medically appropriate or indicated for treatment of an insured's condition, and the health insurer authorizes the use of another medical procedure, course of treatment, or prescription drug prescribed or recommended by the treating provider for the insured's condition.
- "Urgent care situation" is an injury or condition of an insured which, if medical care and treatment is not provided earlier than the time generally considered by the medical profession to be reasonable for a nonurgent situation, in the opinion of the insured's treating physician, would seriously jeopardize the insured's life or health or ability to regain maximum function or subject the patient to severe pain that cannot be managed adequately.

A health insurer is required to publish on its website and provide to an insured in writing the procedure for requesting a protocol exception, including the following:

- A description of the manner in which an insured may request a protocol exception.
- The manner and timeframe in which a health insurer is required to authorize or deny a protocol exception request or respond to an appeal to a health insurer's authorization or denial of a request.
- The conditions in which the protocol exception request must be granted.

As is the case for a response to a request for a prior authorization, the health insurer must authorize or deny a protocol exception request or respond to an appeal of a health insurer's authorization or denial of a request within 24 hours after receipt in an urgent care situation; or within 72 hours after receipt in a nonurgent care situation. The health insurer must include a detailed written explanation of the reason for the denial and the procedure to appeal the denial.

A health insurer must grant a protocol exception request if:

- A preceding prescription drug or medical treatment is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;
- A preceding prescription drug is expected to be ineffective based on the medical history of the insured and the clinical evidence of the characteristics of the preceding prescription drug or medical treatment;
- The insured previously received a preceding prescription drug or another prescription drug or medical treatment that is in the same pharmacologic class or that has the same mechanism of action as a preceding prescription drug, respectively, and the drug or treatment lacked efficacy or effectiveness or adversely affected the insured; or
- A preceding prescription drug or medical treatment is not in the best interest of the insured because the insured's use of the drug or treatment is expected to:
  - Cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care;
  - Worsen the medical condition of the insured that exists simultaneously but independently with the condition under treatment; or
  - Decrease the ability of the insured to achieve or maintain his or her ability to perform daily activities.

The health insurer may request a copy of relevant documentation from the insured's medical record in support of a protocol exception request.

Section 3 provides that the bill takes effect July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The bill does not address whether its provisions apply prospectively to future contracts between a person and an insurer or an HMO or to contracts in existence on the effective date of the bill.

Article I, section 10 of the State Constitution provides:

> **Prohibited laws.—**No bill of attainder, ex post facto law or law impairing the obligation of contracts shall be passed.

This bill may potentially be challenged to the extent that its provisions substantially alter existing contracts, In *Pomponio v. Claridge of Pompano Condominium, Inc*., [22] the Florida Supreme Court reviewed a statute which required the deposit of rent into a court registry during litigation involving obligations under a contract lease. The court invalidated the law as an unconstitutional impairment of contract, after applying a three-prong test."[23] The court noted that the inquiry is not required and the law will stand if the court initially finds that the alteration of contractual obligations is minimal.[24] However, a substantial or severe impairment of an existing contract requires the court to consider whether:

- The law was enacted to deal with a broad, generalized economic or social problem;
- The law operates in an area that was already subject to state regulation at the time the contract was entered into; and
- The effect on the contractual relationships is temporary or whether it is severe, permanent, immediate, and retroactive.[25]

In *United States Fidelity & Guaranty Co. v. Department of Insurance,* the Florida Supreme Court followed *Pomponio*.[26] In so doing, the court stated that the overall query involves a balancing of a person's interest to not have his or her contracts impaired, with the state's interest in exercising legitimate police power.[27] As provided in *Pomponio,* the severity of the impairment increases the level of scrutiny.[28]

Relevant to whether an impairment of contract is constitutional is the degree to which the plaintiff's industry had been regulated in the past. If the industry of the plaintiff was already heavily regulated at the time the plaintiff entered into the contract, further regulation is expected, and therefore considered to be reasonable by the court.[29]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Implementation of the bill may give health care providers greater flexibility in prescribing medications to meet the unique medical needs of their patients and reduce the administrative burden associated with the prior authorization process and the current step therapy or fail-first therapy protocols.

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[22] *Pomponio v. Claridge of Pompano Condominium, Inc.,* 378 So. 2d 774, 779 (Fla. 1979).
[23] *Id*. at 779, 782.
[24] In so doing, the court concluded, "[t]he severity of the impairment measures the height of the hurdle the state legislation must clear." *Id*.
[25] *Id*.
[26] *United States Fidelity & Guaranty Co. v. Department of Insurance,* 453 So. 2d 1355, 1360 (Fla. 1984).
[27] *Id*. at 1360.
[28] *Id*.
[29] *Id*. at 1361.

Insurers and HMOs may experience an indeterminate increase in costs associated with changes in the step therapy protocols provided in the bill, which could increase premiums for purchasers of health insurance, such as consumers,[30] which may include individuals and employers.

The provisions of the bill would not apply to self-insured health plans because plans are preempted from state regulation under the federal Employee Retirement Income Security Act of 1974.

C. Government Sector Impact:

Office of Insurance Regulation[31]

The bill does not have a fiscal impact on the OIR.

Medicaid[32]

According to the agency, the bill will have an indeterminate fiscal impact on the agency. The bill will require the agency to amend the SMMC contracts to modify the prior authorization requirements and the utilization review timeframes. The agency will use current agency resources to amend the contract. The bill will significantly affect the business (staffing, systems, etc.) and clinical operations of the Medicaid managed care plans. The bill requires the plans to shorten the time to review authorizations, which will increase the administrative costs.

Chapter 409, F.S., does not define urgent care. The bill defines an "urgent care situation" to have the same meaning as in s. 627.42393, F.S. As the Medicaid plans are required to comply with s. 627.42392, F.S., with regard to prior authorization, these proposed changes would impact the SMMC plans. This will require amendments to the SMMC contracts to revise existing contractual definitions of these terms and to incorporate their meanings within the scope of work under the SMMC program. While the definition for urgent care will have a minor operational impact and will not have a fiscal impact to the Medicaid program, the application of the urgent care definition to the proposed authorization timeframes will have both a fiscal and operational impact.

The agency notes that the situations specified in the bill, for which a plan would be required to authorize a request for a "protocol exception," should already be contemplated in the plans' clinical or evidence based authorization criteria under the SMMC program and are factors addressed in the application of the State's Medicaid medical necessity definition. All Medicaid managed care plans must use the State's Medicaid medical necessity definition in their approval and denial of services. The timely

[30] Office of Insurance Regulation, *2018 Legislative Bill Analysis of SB 98* (Aug. 30, 2017) (on file with the Senate Committee on Banking and Insurance).
[31] *Id.*
[32] Agency for Health Care Administration, *2018 Legislative Bill Analysis of SB 98* (Oct. 31, 2017) (on file with the Senate Committee on Banking and Insurance).

response standards for protocol exceptions will expedite authorization decisions and require the plans to increase their authorization staff and will result in an increase in administrative expenses. These increased costs will need to be reflected in the SMMC capitation rates as administrative expenses.

Florida State Group Insurance/DMS[33]

The State Group Insurance program indicates that the bill would have a fiscal impact on the program. The program's fully insured health maintenance organization (HMO) vendor, Capital Health Plan (CHP), estimated a fiscal impact of $256,000 annually, based upon the need to employ an additional four medical staff and three support staff employees.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Effective Date

The bill provides an effective date of July 1, 2018. Many commercial plans as well as the Division of State Group Insurance, operate their plans on a calendar year basis. Generally, federal regulations relating to private health insurance require annual rate filings to be submitted prior to July 1. For example, the submission deadline for 2018 ACA-compliant form and rate filings in the individual and small group market was May 3, 2017. This deadline was applicable for products sold on and off the exchange.

The agency notes that at the implementation or effective date of the act, July 1, 2018, the agency and newly contracted managed care plans will be in the process of conducting readiness reviews for implementation of the new contracts. Given the magnitude of the changes proposed in the bill (including system changes, staffing changes, etc.) coinciding with the statutorily required reprocurement of the SMMC program, it would pose operational challenges to Medicaid managed care plans to implement such changes by July 1, 2018. Further, since it is projected that these changes will affect the capitation rate setting process, the agency would need time to work with its actuaries to adjust the rates. An implementation timeframe of January 1, 2019 would align with the full implementation of the new SMMC contracts and allow the agency and their actuaries sufficient time to develop new capitation rates. This would also provide managed care plans with more time to implement any necessary operational changes concurrent with the new contracts, as well as provide the agency with the time needed to modify and execute revised SMMC contracts to reflect the proposed changes.

[33] Department of Management Services, *2018 Legislative Bill Analysis of SB 98* (Oct. 31, 2017) (on file with the Senate Committee on Banking and Insurance).

Implementation

OIR

The provisions of section 1 of the bill apply to health insurers and pharmacy benefit managers on behalf of health insurers. The OIR licenses and regulates health insurers. Insurers may contract with third parties to provide services or functions. Ultimately, the insurer must comply with the provisions of the Insurance Code. The OIR does not license or regulate PBMs. Currently no agency licenses or regulates PBMs. It is unclear whether the health insurer is responsible for the actions of the PBM.

Section 1 of the bill provides that a prior authorization form may not require information that is not necessary for the determination of medical necessity of, or coverage for, the requested medical procedure, course of treatment, or prescription drug. However, it is unclear what information would be deemed "not necessary." This provision may be difficult to enforce. The bill does not provide rulemaking authority for the OIR.

State Group Insurance/DMS[34]

DMS noted concerns of some of its contracted vendors. Specifically, CVS Caremark, a PBM for the State Group Insurance program had concerns regarding lines 83-88, which require "detailed descriptions of requirements and restrictions to obtain prior authorization." CVS Caremark stated that clinical criteria could be specific to each medication and burdensome to a prescriber or member to identify and understand. CVS Caremark also indicated that this language also suggests that the insurer or PBM's confidential and proprietary clinical criteria must be released to the general public, which could be in conflict with what is required by our manufacturer agreements. CVS Caremark raised similar concerns (lines 157-158) regarding the requirement to post publicly the conditions under which the protocol exception request must be granted. CVS Caremark stated that clinical exceptions criteria could be specific to each medication and burdensome to a prescriber or member to identify and understand. Further, CVS Caremark stated that this language also suggests that the insurer or PBM's confidential and proprietary clinical exceptions criteria must be released to the general public which could be in conflict with what is required by CVS Caremark's manufacturer agreements.

Notice of Prior Authorization Changes

Section 1 of the bill requires health insurers or a PBM to provide at least 60 days' prior notice to insureds and physicians prior to implementing new requirements or restrictions to the prior authorization process. However, the bill does not allow for exceptions in circumstances where a drug or procedure is found to be hazardous or could result in harm to an insured.

VIII. Statutes Affected:

This bill substantially amends section 627.42392 of the Florida Statutes.

This bill creates section 627.42393 of the Florida Statutes.

[34] *Id.*

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Steube

23-00013-18 201898__

A bill to be entitled

An act relating to health insurer authorization; amending s. 627.42392, F.S.; redefining the term "health insurer"; defining the term "urgent care situation"; prohibiting prior authorization forms from requiring certain information; requiring health insurers and pharmacy benefits managers on behalf of health insurers to provide certain information relating to prior authorization by specified means; prohibiting such insurers and pharmacy benefits managers from implementing or making changes to requirements or restrictions to obtain prior authorization except under certain circumstances; providing applicability; requiring such insurers and pharmacy benefits managers to authorize or deny prior authorization requests and provide certain notices within specified timeframes; creating s. 627.42393, F.S.; defining terms; requiring health insurers to publish on their websites and provide to insureds in writing a procedure for insureds and health care providers to request protocol exceptions; specifying requirements for such procedure; requiring health insurers, within specified timeframes, to authorize or deny a protocol exception request or respond to appeals of their authorizations or denials; requiring authorizations or denials to specify certain information; requiring health insurers to grant protocol exception requests under certain circumstances; authorizing health insurers to request

23-00013-18 201898__

documentation in support of a protocol exception request; providing an effective date.

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

Section 1. Section 627.42392, Florida Statutes, is amended to read:

627.42392 Prior authorization.—

(1) As used in this section, the term:

(a) "Health insurer" means an authorized insurer offering an individual or group insurance policy that provides major medical or similar comprehensive coverage ~~health insurance as defined in s. 624.603~~, a managed care plan as defined in s. 409.962(10), or a health maintenance organization as defined in s. 641.19(12).

(b) "Urgent care situation" has the same meaning as in s. 627.42393.

(2) Notwithstanding any other provision of law, effective January 1, 2017, or six (6) months after the effective date of the rule adopting the prior authorization form, whichever is later, a health insurer, or a pharmacy benefits manager on behalf of the health insurer, which does not provide an electronic prior authorization process for use by its contracted providers, shall only use the prior authorization form that has been approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation, and must include all clinical

documentation necessary for the health insurer to make a decision. At a minimum, the form must include: (1) sufficient patient information to identify the member, date of birth, full name, and Health Plan ID number; (2) provider name, address and phone number; (3) the medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed; (4) any laboratory documentation required; and (5) an attestation that all information provided is true and accurate. The form, whether in electronic or paper format, may not require information that is not necessary for the determination of medical necessity of, or coverage for, the requested medical procedure, course of treatment, or prescription drug.

(3) The Financial Services Commission in consultation with the Agency for Health Care Administration shall adopt by rule guidelines for all prior authorization forms which ensure the general uniformity of such forms.

(4) Electronic prior authorization approvals do not preclude benefit verification or medical review by the insurer under either the medical or pharmacy benefits.

(5) A health insurer or a pharmacy benefits manager on behalf of the health insurer must provide the following information in writing or in an electronic format upon request, and on a publicly accessible Internet website:

(a) Detailed descriptions of requirements and restrictions to obtain prior authorization for coverage of a medical procedure, course of treatment, or prescription drug in clear, easily understandable language. Clinical criteria must be described in language easily understandable by a health care

provider.

(b) Prior authorization forms.

(6) A health insurer or a pharmacy benefits manager on behalf of the health insurer may not implement any new requirements or restrictions or make changes to existing requirements or restrictions to obtain prior authorization unless:

(a) The changes have been available on a publicly accessible Internet website at least 60 days before the implementation of the changes.

(b) Policyholders and health care providers who are affected by the new requirements and restrictions or changes to the requirements and restrictions are provided with a written notice of the changes at least 60 days before the changes are implemented. Such notice may be delivered electronically or by other means as agreed to by the insured or health care provider.

This subsection does not apply to expansion of health care services coverage.

(7) A health insurer or a pharmacy benefits manager on behalf of the health insurer must authorize or deny a prior authorization request and notify the patient and the patient's treating health care provider of the decision within:

(a) Seventy-two hours of obtaining a completed prior authorization form for nonurgent care situations.

(b) Twenty-four hours of obtaining a completed prior authorization form for urgent care situations.

Section 2. Section 627.42393, Florida Statutes, is created to read:

627.42393 Fail-first protocols.—

(1) As used in this section, the term:

(a) "Fail-first protocol" means a written protocol that specifies the order in which a certain medical procedure, course of treatment, or prescription drug must be used to treat an insured's condition.

(b) "Health insurer" has the same meaning as provided in s. 627.42392.

(c) "Preceding prescription drug or medical treatment" means a medical procedure, course of treatment, or prescription drug that must be used pursuant to a health insurer's fail-first protocol as a condition of coverage under a health insurance policy or a health maintenance contract to treat an insured's condition.

(d) "Protocol exception" means a determination by a health insurer that a fail-first protocol is not medically appropriate or indicated for treatment of an insured's condition and the health insurer authorizes the use of another medical procedure, course of treatment, or prescription drug prescribed or recommended by the treating health care provider for the insured's condition.

(e) "Urgent care situation" means an injury or condition of an insured which, if medical care and treatment are not provided earlier than the time generally considered by the medical profession to be reasonable for a nonurgent situation, in the opinion of the insured's treating physician, would:

1. Seriously jeopardize the insured's life, health, or ability to regain maximum function; or

2. Subject the insured to severe pain that cannot be

adequately managed.

(2) A health insurer must publish on its website and provide to an insured in writing a procedure for an insured and health care provider to request a protocol exception. The procedure must include:

(a) A description of the manner in which an insured or health care provider may request a protocol exception.

(b) The manner and timeframe in which the health insurer is required to authorize or deny a protocol exception request or respond to an appeal of a health insurer's authorization or denial of a request.

(c) The conditions under which the protocol exception request must be granted.

(3)(a) The health insurer must authorize or deny a protocol exception request or respond to an appeal of a health insurer's authorization or denial of a request within:

1. Seventy-two hours of obtaining a completed prior authorization form for nonurgent care situations.

2. Twenty-four hours of obtaining a completed prior authorization form for urgent care situations.

(b) An authorization of the request must specify the approved medical procedure, course of treatment, or prescription drug benefits.

(c) A denial of the request must include a detailed, written explanation of the reason for the denial, the clinical rationale that supports the denial, and the procedure to appeal the health insurer's determination.

(4) A health insurer must grant a protocol exception request if:

(a) A preceding prescription drug or medical treatment is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(b) A preceding prescription drug is expected to be ineffective, based on the medical history of the insured and the clinical evidence of the characteristics of the preceding prescription drug or medical treatment;

(c) The insured has previously received a preceding prescription drug or medical treatment that is in the same pharmacologic class or has the same mechanism of action, and such drug or treatment lacked efficacy or effectiveness or adversely affected the insured; or

(d) A preceding prescription drug or medical treatment is not in the best interest of the insured because the insured's use of such drug or treatment is expected to:

1. Cause a significant barrier to the insured's adherence to or compliance with the insured's plan of care;

2. Worsen an insured's medical condition that exists simultaneously but independently with the condition under treatment; or

3. Decrease the insured's ability to achieve or maintain his or her ability to perform daily activities.

(5) The health insurer may request a copy of relevant documentation from the insured's medical record in support of a protocol exception request.

Section 3. This act shall take effect July 1, 2018.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Judiciary, *Chair*
Banking and Insurance, *Vice Chair*
Agriculture
Appropriations Subcommittee on Finance and Tax
Appropriations Subcommittee on Pre-K - 12 Education
Children, Families, and Elder Affairs
Regulated Industries

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR GREG STEUBE
23rd District

August 28, 2017

The Honorable Anitere Flores
Florida Senate
404 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Flores,

I am writing this letter because my bill, SB 98 – Health Insurer Authorization, has been referred to the Senate Banking and Insurance Committee. I am respectfully requesting that you place the bill on your committee's calendar for the next committee week.

Thank you for your consideration. Please contact me if you have any questions.

Very respectfully yours,

W. Gregory Steube, District 23

REPLY TO:
❒ 6230 University Parkway, Suite 202, Sarasota, Florida 34240 (941) 342-9162
❒ 326 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5023

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

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

11-7-17
Meeting Date

SB 98
Bill Number (if applicable)

Topic Health Insurer Auth

Amendment Barcode (if applicable)

Name Audrey Brown

Job Title President and CEO

Address 200 W. College Ave
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone (850)386-2904

Email audray@fahp.net

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/7/17
Meeting Date

98
Bill Number (if applicable)

Topic patient access

Amendment Barcode (if applicable)

Name Natalie Blake

Job Title Director of Programs + Services

Address 6520 N Andrews Ave
Street

Phone

Ft. Lauderdale FL 33309
City *State* *Zip*

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Multiple Sclerosis Foundation

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

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11/7/17
Meeting Date

98
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Noland

Job Title _____

Address 1000 Riverside Ave
Street

Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email Noandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Chapter, American College of Surgeons

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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11/7/17
Meeting Date

98
Bill Number (if applicable)

Topic Health Insurer Authorization

Amendment Barcode (if applicable)

Name Mary Thomas

Job Title Assistant General Consel

Address 1430 Piedmont Dr E
Street

TLH FL 32308
City *State* *Zip*

Phone 8502241649

Email MThomas@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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11/7/17
Meeting Date

SB 98
Bill Number (if applicable)

Topic Health Insurer Authorization

Amendment Barcode (if applicable)

Name Zayne Smith

Job Title Associate State Director

Address 200 W College St.
Street

Phone 850.228.42.43

Tally FL 32301
City *State* *Zip*

Email zsmith@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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11-7-2017
Meeting Date

SB 98
Bill Number (if applicable)

Topic HEALTH INSURER AUTHORIZATION

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLARSTONE PINES DRIVE
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

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

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

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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11/7/17
Meeting Date

98
Bill Number (if applicable)

Topic Health Insurer Authorization

Amendment Barcode (if applicable)

Name Jill Grau

Job Title Policy Director

Address 2868 Mahan Dr
Street

Phone 850 878 2196

Tallahassee FL 32308
City *State* *Zip*

Email jill@myfbha.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Behavioral Health Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/7/17
Meeting Date

98
Bill Number (if applicable)

Topic patient access

Amendment Barcode (if applicable)

Name Cheryl Elias

Job Title Vice President

Address PO Box 150813
Street

Phone

Tallahassee, FL 32315
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing HEALS of the South

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

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11/7/17
Meeting Date

98
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic patient access

Name Nicole Hill

Job Title Board Member

Address 1302 E 10th Ave
Street

Tallahassee, FL 32303
City *State* *Zip*

Phone

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Epilepsy Association of the Big Bend

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

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11-7-17
Meeting Date

SB 98
Bill Number (if applicable)

Topic Health Insurer Authorization

Amendment Barcode (if applicable)

Name Pierce Schuessler (shoes-ler)

Job Title Lobbyist - Metz,Husband and Daughton

Address 119 South Monroe Street
Street

Phone 205-9000

Tallahassee FL 32303
City *State* *Zip*

Email Pierce.Schuessler@mhdfirm.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Chapter of American Academy of Pediatrics

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/7
Meeting Date

98
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Laura Stargel

Job Title _____

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

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

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

Representing American Cancer Society

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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11/7/17
Meeting Date

98
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic ~~step~~ prior auth

Name Toni Large

Job Title

Address 519 E. Park Ave
Street
Tallahassee FL
City *State* *Zip*

Phone (850)556-1401

Email toni@sulaw.net

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

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

Representing FL Society of Rheumatology

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

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

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

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 220
INTRODUCER:	Senator Passidomo
SUBJECT:	Bankruptcy Matters in Foreclosure Proceedings
DATE:	November 6, 2017 REVISED:

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

I. Summary:

SB 220 allows a lienholder in a foreclosure proceeding to use documents filed in a defendant's bankruptcy case. A mortgage foreclosure is a legal action by a lender against a debtor to force the sale of real property that secures a defaulted-upon loan. The proceeds of the sale are used to repay the debt. Often, a debtor subject to foreclosure will file for bankruptcy as a means of obtaining an automatic stay of the foreclosure action and a discharge of the mortgage debt.

In bankruptcy, a debtor must file a statement under penalty of perjury stating his or her intent to retain, redeem, or surrender any property securing a debt. The debtor is supposed to act on that decision as a condition of obtaining a discharge of his or her debts. In some cases, debtors have stated an intention to surrender real property in bankruptcy proceedings, but later have actively contested the completion of a foreclosure proceeding regarding the property in state court.

This bill allows for documents filed under a penalty of perjury in a bankruptcy case to be filed in a mortgage foreclosure proceeding as admissions against the debtor/mortgagor. The bill also creates a rebuttable presumption that a defendant has waived any defense to a foreclosure action if the lienholder submits documents filed in the defendant's bankruptcy case which:

- Evidence intention to surrender to the lienholder the property that is the subject of the foreclosure;
- Have not been withdrawn by the defendant; and
- Show that a final order that discharges the defendant's debts or confirms the defendant's repayment plan that provides for surrender of the property.

A defendant can still raise a defense based upon the lienholder's action or inaction subsequent to the filing of the document which evidenced the defendant's intent to surrender the property.

The bill also requires a court in foreclosure proceeding, upon the request of a lienholder, to take judicial notice of any order entered in a bankruptcy case.

II. Present Situation:

Mortgage Foreclosure

The Florida Rules of Civil Procedure and a statutory process govern mortgage foreclosure. Foreclosure is initiated by the lender or servicer, known as the mortgagee, when the borrower, or mortgagor, fails to perform the terms of his or her mortgage, usually by defaulting on payments. Most mortgages contain an "acceleration clause," which gives the mortgagee the authority to declare the entire mortgage obligation due and payable immediately upon default. If the borrower is not able to pay the entire mortgage obligation upon proper notice, the holder of the note or its servicing agent may begin the foreclosure process in a court of proper jurisdiction. The following is a general outline of the judicial foreclosure process:

- Upon proper notice of default to the defendant, the mortgage servicer files a foreclosure complaint;[1]
- Service of process must be made on defendants within 120 days after the filing of the initial pleadings;[2]
- If a defendant has not filed an answer or another paper indicating an intent to respond to the suit, then the plaintiff is entitled to an entry of default against the defendant;[3]
- If an answer is filed, the plaintiff may then file for a motion of summary judgment or proceed to trial, however the vast majority of plaintiffs file a motion for summary judgment;[4]
- Following the proper motions, answers, affidavits, and other evidence being filed with the court, the judge holds a summary judgment hearing and renders a final judgment if he or she finds in the favor of the plaintiff;[5]
- If summary judgment is denied, the foreclosure proceeds to a trial without a jury;[6]
- If the plaintiff prevails, the court schedules a judicial sale of the property not less than 20 days, but no more than 35 days after the judgment;[7]
- A notice of sale must be published once a week, for 2 consecutive weeks, in a publication of general circulation, and the second publication must be at least 5 days prior to the sale;[8]
- The winning bid at a public judicial sale is conclusively presumed to be sufficient consideration for the sale;[9]
- Parties have 10 days to file a verified objection to the amount of the bid or the sale procedure;[10]
- After the 10 days has expired with no objection, the sale is confirmed by the clerk's issuance of the certificate of title to the purchaser, sale proceeds are disbursed, and the court may, in its discretion, enter a deficiency decree for the difference between the fair market value of the security received and the amount of the debt;[11] and

[1] Fla.R.Civ.P. Form 1.944.
[2] Fla.R.Civ.P. 1.070(j).
[3] Fla.R.Civ.P. 1.500.
[4] Fla.R.Civ.P. 1.510(a).
[5] Section 45.031, F.S.
[6] Section 702.01, F.S.
[7] Section 45.031(1)(a), F.S.
[8] Section 45.031(2), F.S.
[9] Section 45.031(8), F.S.
[10] Section 45.031(8), F.S.
[11] Section 702.06, F.S.

- The clerk may issue a writ of possession giving possession of the real property to the purchaser and directing the sheriff to assist that purchaser with obtaining possession. Up to the point that a writ of possession is served on the property, the debtor who was foreclosed has the legal right to stay in possession of the real property.

Bankruptcy Proceedings

In general, the two purposes of bankruptcy are to convert the estate of the debtor into cash and distribute it among creditors, and to give the debtor a fresh start with such exemptions and rights as the bankruptcy statute leaves untouched.[12] The filing of a bankruptcy petition operates as an automatic stay on most legal actions against a debtor, including foreclosure.[13] The automatic stay is in effect from the time the petition is filed until discharge of the debtor, unless sooner lifted by the bankruptcy court.

For individuals, there are two primary forms of bankruptcy. A petition filed pursuant to Chapter 7 of the bankruptcy code is used when the rehabilitative chapters of the code would not be applicable, such as when there is no nonexempt property to protect.[14] A Chapter 13 petition allows the debtor to stay creditor actions and propose a plan to pay creditors, rehabilitating the debtor financially.[15]

In a Chapter 7 bankruptcy, the debtor must express his or her intent regarding secured property. A debtor has four options:

- Declare the secured property is exempt;
- Surrender the property and be discharged of the debt;
- Reaffirm the debt, meaning the debtor keeps the property but is liable for the debt in the future (the debt is not discharged by bankruptcy); or
- Redeem the property by paying cash to pay off the security interest.[16]

The statement of intent must be made under penalty of perjury. The debtor must file the statement of intent within 30 days of the filing of the Chapter 7 petition or on or before the date of the meeting of the creditors to appoint a trustee for the estate, whichever date is earlier.[17] Within 30 days after the first set date for the meeting of the creditors, the debtor must perform his intention with respect to each piece of secured property.[18]

In Chapter 13 filings, the debtor must create a plan to restructure and repay his debt.[19] For this plan to be confirmed by the court, it must describe how the debtor is responding to each secured

[12] 9 Am Jur 2d Bankruptcy Section 5.
[13] 11 U.S.C. 362(a)(4).
[14] 9 Am Jur 2d Bankruptcy Section 68.
[15] 9 Am Jur 2d Bankruptcy Section 72.
[16] *In re Failla*, 838 F.3d 1170 (11th Cir. 2016).
[17] 9 AmJur 2d Bankruptcy Section 72.
[18] 11 U.S.C. 521.
[19] 11 U.S.C. 1321 and 1322.

claim.[20] The debtor must make a plan for the secured property that the holder of the claim accepts or the debtor surrenders the property securing the claim to the claim holder.[21]

After the debtor has fulfilled his or her duties to the bankruptcy estate, the debtor may receive a discharge.[22] This discharge voids any dischargeable debt of the debtor, including a deficiency judgment that might otherwise be obtained after surrender of secured property to a creditor.

Florida Evidence Code

The Florida Evidence Code governs what evidence may be used in court actions in the state courts.[23] Sections 90.201 and 90.202, F.S., provide that a court may take judicial notice of certain facts. Judicial notice is the authority of a judge to accept as facts certain matters which are of common knowledge from sources which guarantee accuracy or are a matter of official record, without the need for evidence establishing the fact.[24] A court may take judicial notice of records of any court of this state or any court of record of the United States.[25]

The Florida Evidence Code generally prohibits hearsay testimony.[26] An exception to the hearsay prohibition is a written admission of an opposing party.[27]

Recent Cases Regarding Surrender of Real Property in Bankruptcy

There have been cases where a debtor has agreed to surrender the property in a federal bankruptcy proceeding but have continued to fight the foreclosure proceeding in state court.[28] In *In re Failla*,[29] the debtors filed for bankruptcy in 2011. They admitted that they owned the home, that the home was collateral for the mortgage, and that the mortgage was valid. They filed a statement of their intention to surrender the home in the bankruptcy proceedings. After the filing of their intention to surrender, the debtors continued to live in the home and defend against the creditor's ongoing foreclosure action in state court. The debtors argued that the effect of the surrender was simply to lift the automatic stay and allow the creditor to proceed with a foreclosure action in state court.[30] The court held that stating an intention to surrender in bankruptcy court meant that the debtors could not contest the foreclosure action in state court.[31]

[20] 11 U.S.C. 1325(a)(5).
[21] 11. U.S.C. 1325(a)(5).
[22] 11 U.S.C. 727.
[23] Section 90.103, F.S.
[24] *See* http://dictionary.law.com/Default.aspx?selected=1065 (last accessed February 23, 2017).
[25] Section 90.202(6), F.S.
[26] Section 90.802, F.S.
[27] Section 90.803(18), F.S.
[28] *See, e.g.*,*Green Tree Servicing v. Hardmon*, Case No. 162012-CA-13629-FC-E (Fla. 4th Judicial Circuit November 13, 2015); *In re Guerra*, 544 B.R. 707 (Bankr. M.D. Fla. 2016); *In re Metzler*, 530 B.R. 894 (Bankr. M.D. Fla. 2015).
[29] *In re Failla*, 838 F.3d 1170 (11th Cir. 2016).
[30] *In re Failla*, 838 F.3d at 1173-1175.
[31] *In re Failla*, 838 F.3d at 1178.

III. Effect of Proposed Changes:

The bill addresses the problem of a debtor in a bankruptcy action declaring his or her intention to give up property, then litigating to keep the property in a foreclosure action. It allows for documents filed under penalty of perjury in a bankruptcy case to be filed subsequently in a mortgage foreclosure proceeding as admissions against a debtor/mortgagor.

The bill creates a rebuttable presumption that the defendant has waived any defense to a foreclosure if the lienholder submits documents from the defendant's bankruptcy case which:

- Evidence intention to surrender to the lienholder the property that is the subject of the foreclosure;
- Have not have been withdrawn by the defendant; and
- Show that a final order has been entered in the defendant's bankruptcy case which discharges the defendant's debts or confirms the defendant's repayment plan that provides for surrender of the property.

The bill does not preclude a defendant from raising a defense based on the lienholder's action or inaction subsequent to the filing of the document in the bankruptcy case.

The bill also requires the court in a foreclosure case to take judicial notice, pursuant to s. 90.203, F.S., of any order entered in a bankruptcy case upon the request of a lienholder.

The bill takes effect on October 1, 2018, and applies to foreclosure actions filed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill could have the effect of some expediting foreclosure cases.

C. Government Sector Impact:

The bill could expedite some foreclosure cases in the state court system.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 702.12 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Passidomo

28-00027-18 2018220__

A bill to be entitled

An act relating to bankruptcy matters in foreclosure proceedings; creating s. 702.12, F.S.; authorizing lienholders to use certain documents as an admission in an action to foreclose a mortgage; providing that submission of certain documents in a foreclosure action creates a rebuttable presumption that the defendant has waived any defenses to the foreclosure; requiring a court to take judicial notice of orders entered in bankruptcy cases under certain circumstances; providing construction; providing applicability; providing an effective date.

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

Section 1. Section 702.12, Florida Statutes, is created to read:

702.12 Actions in foreclosure.—

(1)(a) A lienholder, in an action to foreclose a mortgage, may submit any document the defendant filed under penalty of perjury in the defendant's bankruptcy case for use as an admission by the defendant.

(b) A rebuttable presumption that the defendant has waived any defense to the foreclosure is created if a lienholder submits documents filed in the defendant's bankruptcy case which:

1. Evidence the defendant's intention to surrender to the lienholder the property that is the subject of the foreclosure;

2. Have not been withdrawn by the defendant; and

28-00027-18 2018220__

3. Show that a final order has been entered in the defendant's bankruptcy case which discharges the defendant's debts or confirms the defendant's repayment plan that provides for the surrender of the property.

(2) Pursuant to s. 90.203, a court shall take judicial notice of an order entered in a bankruptcy case upon the request of a lienholder.

(3) This section does not preclude the defendant in a foreclosure action from raising a defense based upon the lienholder's action or inaction subsequent to the filing of the document filed in the bankruptcy case which evidenced the defendant's intention to surrender the mortgaged property to the lienholder.

(4) This section applies to any foreclosure action filed on or after October 1, 2018.

Section 2. This act shall take effect October 1, 2018.

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

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, President Pro Tempore
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: 10/3/2017

I respectfully request that Senate Bill 220 , relating to Foreclosures , be placed on the:

☑ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Kathleen Passidomo
Florida Senate, District 28

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/7/17
Meeting Date

SB 220
Bill Number (if applicable)

Topic Bankruptcy Matters in Foreclosure Proceedings

Amendment Barcode (if applicable)

Name Kenneth Pratt

Job Title Senior VP of Govt. Affairs

Address 1001 Thomasville Rd, Ste 201
Street

Phone 850-509-8020

Tallahassee FL 32301
City *State* *Zip*

Email kpratt@floridabankers.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Bankers Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

Florida Office of Insurance Regulation

Managed Repair Programs

Presented to:

Senate Banking & Insurance Committee
November 7, 2017

History of Managed Repair Programs

- First Company licensed in 2008 with a business plan centered around Managed Repair
- 2010 - First record of a Form filed by an insurer to implement a Managed Repair program
- Not unique:
  - Health Insurance: Preferred Provider Organizations, Health Maintenance Organizations
  - Auto Insurance: Glass and Collision Repair Vendors, Medical Services Providers
- Used to control insurer claim costs and rising insurance premiums
- Currently in use by 9 Florida property insurers; 2 more have Form filings pending

Managed Repair Program Provisions

Programs and policy provisions vary among insurers:

- May provide consumers with incentives, such as:
  - a deductible waiver, credit, or loan for using a preferred vendor at the time of loss; or
  - A premium credit at the time the policy is issued; or
  - Increased coverage if a preferred vendor is used

Managed Repair vs. Election to Repair

Managed Repair	Election to Repair
This endorsement allows us at our option to select a qualified pre-approved vendor or contractor to make covered repairs to your dwelling or other structures.	*We may, at our option, repair, rebuild, or replace the damaged property with material or property of like kind and quality.*
Insurer provides insureds with incentives for using managed repair vendors such as a premium discount, loan, deductible credit, or increased coverage.	Insurer elects to repair or replace the damaged property in lieu of making payment directly to the insured with no corresponding incentive.
Policy limits apply to the cost for the cost of repairs.	The cost of repairs may exceed the policy limits.
Insured may elect not to use a managed repair vendor but forfeits incentives, if any are provided.	The insurer selects the vendor.
Insurer guarantees the vendor's work.	Insurer guarantees the vendor's work.

Oversight

- The Office must review and approve the forms and rates used for any Managed Repair program that provides consumers with incentives for using a preferred contractor
- Insurers must demonstrate that the incentives are actuarially supported
- Policy forms must contain clear, unambiguous language that is not arbitrary or unfairly discriminatory

Recommendations for Legislative Action

- Insurers' increased use of Managed Repair programs or Election to Repair is a reaction to the increased losses associated with water loss trends and Assignment of Benefits.

- Passage of meaningful Assignment of Benefits legislation.

Citizens Property Insurance Corporation
Managed Repair Program

Barry Gilway

President, CEO and Executive Director

CITIZENS
PROPERTY INSURANCE CORPORATION

Managed Repair Overview

Available for Non-Weather Water Losses for Citizens' HO-3 and DP-3 Policies

- Offered at time of loss for water losses caused by accidental discharge or overflow of water or steam from a plumbing, heating, air conditioning, automatic fire protective sprinkler system or household appliance
- Participation is optional
- Provided through two endorsements

1. **Emergency Water Removal Services Endorsement**
   - No deductible
   - No cost to policyholder even if loss is not covered by Citizens
   - If the policyholder agrees to participate, Citizens provides a Citizens-approved contractor(s) to provide water removal and drying services to protect insured structures from further damage

2. **Managed Repair Contractor Network Program**
   - Provides permanent repair services for covered damage
   - Policyholder works with licensed and insured contractors within the network
   - All contractors' claim related work is guaranteed for three years

2018 Policy Changes

- Effective for HO-3 and dwelling DP-3 new business and renewals May 1, 2018
- $10,000 Sublimit for Coverages A and B if Managed Repair Contractor Network not used
- Requires all claimants other than insured, their agent, representative or a public adjuster representing claimant to
  - Provide documentation supporting the right to make a claim
  - Provide documentation detailing the scope and amount of loss
  - Participate in appraisal or alternative dispute resolution

Managed Repair Contracting Network

Managed Repair Contractor Network Program Processing

Citizens has partnered with Crawford Contractor Connection to administrate a network of licensed, qualified, and credentialed contractors to perform permanent repairs based on nationally recognized estimates and quality standards that ensure the damage is repaired to pre-loss condition

Contact Policyholder	Within one calendar day after first notice of loss (FNOL) by both the Contractor and a Citizens' Adjuster
Loss Inspection	Within two calendar days, Contractor and Adjuster will inspect and prepare a repair estimate based on the Adjuster's identified scope of covered damages
Repair Estimate Approval	Contractor submits to Citizens' Adjuster for review and approval
Citizens' Claim Assignment	Once the repair estimate is approved, Citizens' Claims staff is assigned
Estimate Explained	Citizens' Claims staff explain repair estimate to policyholder and offer managed repair option
Policyholder Decision (two options)	1) Allow the Contractor to perform the repair services • No limit on the loss amount • 3 year guarantee on repairs • Certificate of satisfaction at the completion of the repairs; signed by policyholder
	2) Complete repairs with a contractor of their own choosing • Subject to $10,000 limit

Note: Citizens' claim settlement payment will be based on the estimate provided by the Contractor Connection contractor. To ensure quality control standards are maintained, policyholders may be selected randomly to participate in a voluntary reinspection audit by a Citizens Claims Quality representative.

Claimant Duties After Loss

Change to Policy Language:

For all other claimants seeking benefits under SECTION I of the Policy, in the case of a loss to covered, property, we have no duty to provide coverage under this Policy to a claimant, if the failure to comply with the following duties is prejudicial to us:

a. Provide documentation that substantiates the claimant's right to bring a claim under this Policy, and permit us to make copies;
b. Provide documentation that details, itemizes, and substantiates the scope and amount of loss for which the claimant is making a claim under this Policy, including all updates to the scope and revised documentation, and permit us to make copies; and
c. Participate in appraisal or other alternative dispute resolution method in accordance with the terms of the Policy.

These duties must be performed as often as we reasonably require, by each of the following:

a. A claimant seeking benefits;
b. The claimant's agents;
c. The claimant's representatives; and
d. Any public adjuster engaged on the claimant's behalf

The duties above apply regardless of whether a claimant seeking benefits under the Policy, or their agent or representative, retains or is assisted by a party who provides legal advice, insurance advice or expert claims advice, regarding an insurance claim under this Policy.

For purposes of this condition B.2. a claimant does not include an "insured."

Why is Managed Repair Needed?

The Managed Repair Program was developed in direct response to adverse development in non weather water losses primarily caused by the policyholder's accepting representation that ultimately filed suit on the claim

Through 2017, litigated water claims continue to be the sole driver of an indicated rate increase

- Litigated claims have an average loss and ALAE of $38,000
- Non-litigated claims have an average loss and ALAE of $6,400

The percentage of claims expected to enter litigation has remained at historical and unsustainable highs for 2016 and 2017. This leads to the expectation that in South East Florida, the litigation rate for HO-3 water claims will be over 70%.

Representation at First Notice of Loss (FNOL) – Claim is reported by an attorney or a public adjuster. A claim with representation at FNOL has an **80%** chance of ending up in litigation. A claim without representation at FNOL has a **30%** chance of ending up in litigation.

Assignment of Benefits (AOB) - When there is an AOB associated with a claim, there is an **82%** chance the claim will end up in litigation. When there is no AOB associated with the claim, there is a **34%** chance the claim will end up in litigation.

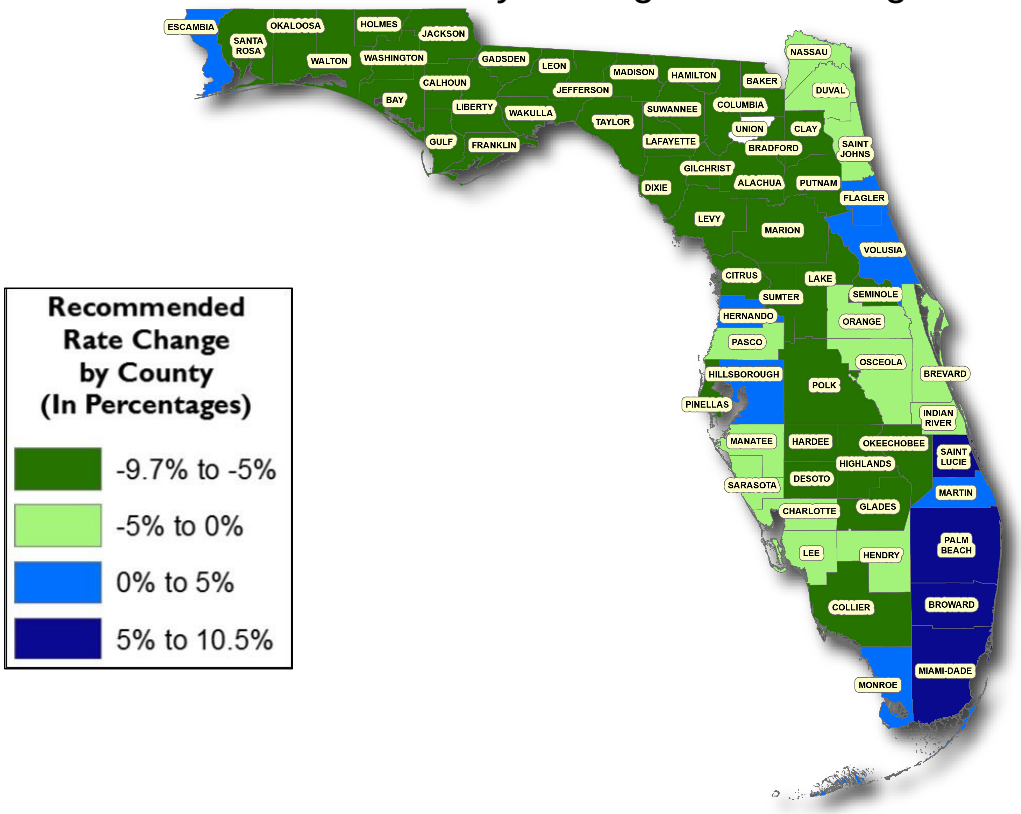
In 2016 in Miami-Dade, 92 cents of every premium dollar went to water claims and associated adjusting costs for PLA Homeowner premiums

With no policy changes, South East Florida would be facing over a decade of 10% rate increases. The intent of the Managed Repair Program and policy changes is to lower litigation rates.

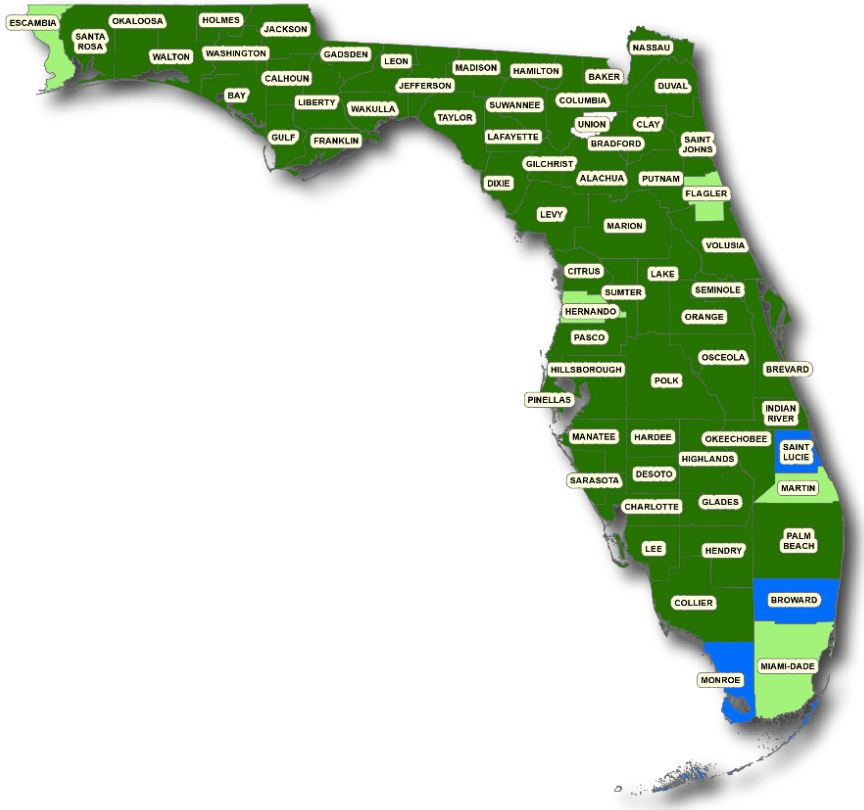
If the policy changes work as intended, actuarially sound rates will be achieved in a few years, at an overall lower rate

Water Losses are the Driver of Higher Premiums

Water Loss Trend at **Current Level**
Multi-Peril HO3 County Average Rate Changes



Water Loss Trends at **pre-2013 Levels**
Multi-Peril HO3 County Average Rate Changes



Water Loss Levels	Number of HO3 Rate Decreases in 2018
Pre-2013 Base Trend	112,000 out of 148,000
2018 Indication	47,000 out of 148,000

NOTES:
1) Percentage of rate change is the average rate change within a given county
2) Policy holders within a given county can see a rate change between -10% and 10% excluding effects of the FHCF build-up pass through

Citizens Policyholders with Access to the Program

Personal Residential Multi-peril Policies

	Homeowner HO-3	Dwelling DP-3	Total	% of Total
Palm Beach	10,762	6,366	17,128	8%
Broward	26,673	8,553	35,226	16%
Miami-Dade	54,341	18,677	73,018	33%
All Other Counties	67,555	29,335	96,890	44%
Statewide Total	**159,331**	**62,931**	**222,262**	**100%**

These policies make up 60% of Citizens' personal residential multi peril book of business

NOTES:
1) In force data as of 09/30/2017
2) Policy counts exclude risks tagged for depopulation

Why a $10,000 limit?

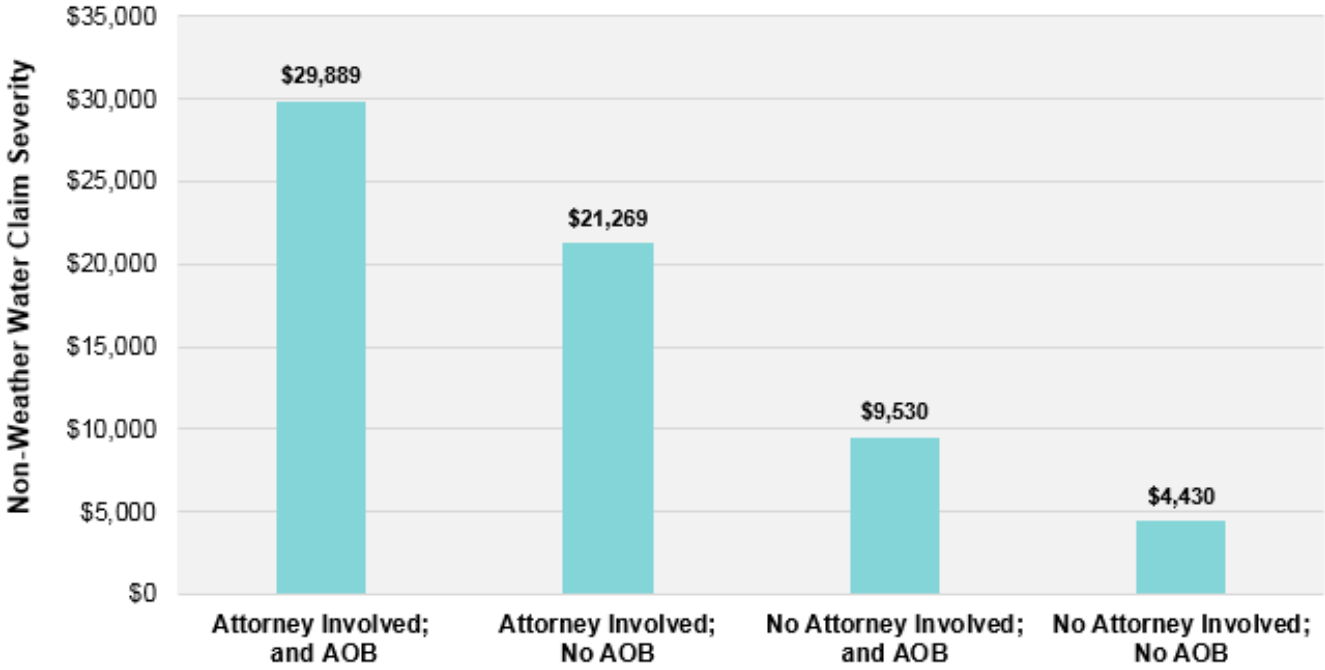
- The $10,000 limit is a Florida Industry standard introduced by the private market for water claims on older homes
- 80% of Citizens' undisputed non-weather water claims are settled for less than $10,000
- Repairs under the Managed Repair Program are not subject to the $10,000 cap
- Ensures larger repairs are completed by licensed, qualified, and credentialed contractors with a three year warranty on repairs made

How Was a Vendor Selected?

- Citizens utilized a Request for Proposal (RFP) to solicit the services of a program administrator
  - The contract would be awarded to an administrator of a program that could be inclusive of all Florida based contractors
- Crawford Contractor Connection was selected for a term of 5 years with two, two year renewal options
- Crawford Contractor Connection selects contractors to be included in Citizens MRP. Our contract with Crawford stipulates minimum requirements for contractors including:
  - Evidence of a business in good standing such as, registration with FL Division of Corporations, necessary tax documents (W-9), completion of a vendor conflict of interest disclosure form each year, certifications of minimum insurance requirements
  - For specific contractors conduct background checks, ethics and confidentiality forms, verification that necessary licenses and certifications are current, required photos of Project Supervisors

Any Florida contractor may participate in the program if they meet the Crawford Contractor Connection minimum requirements

HO-3 Non-Weather Water Loss Data

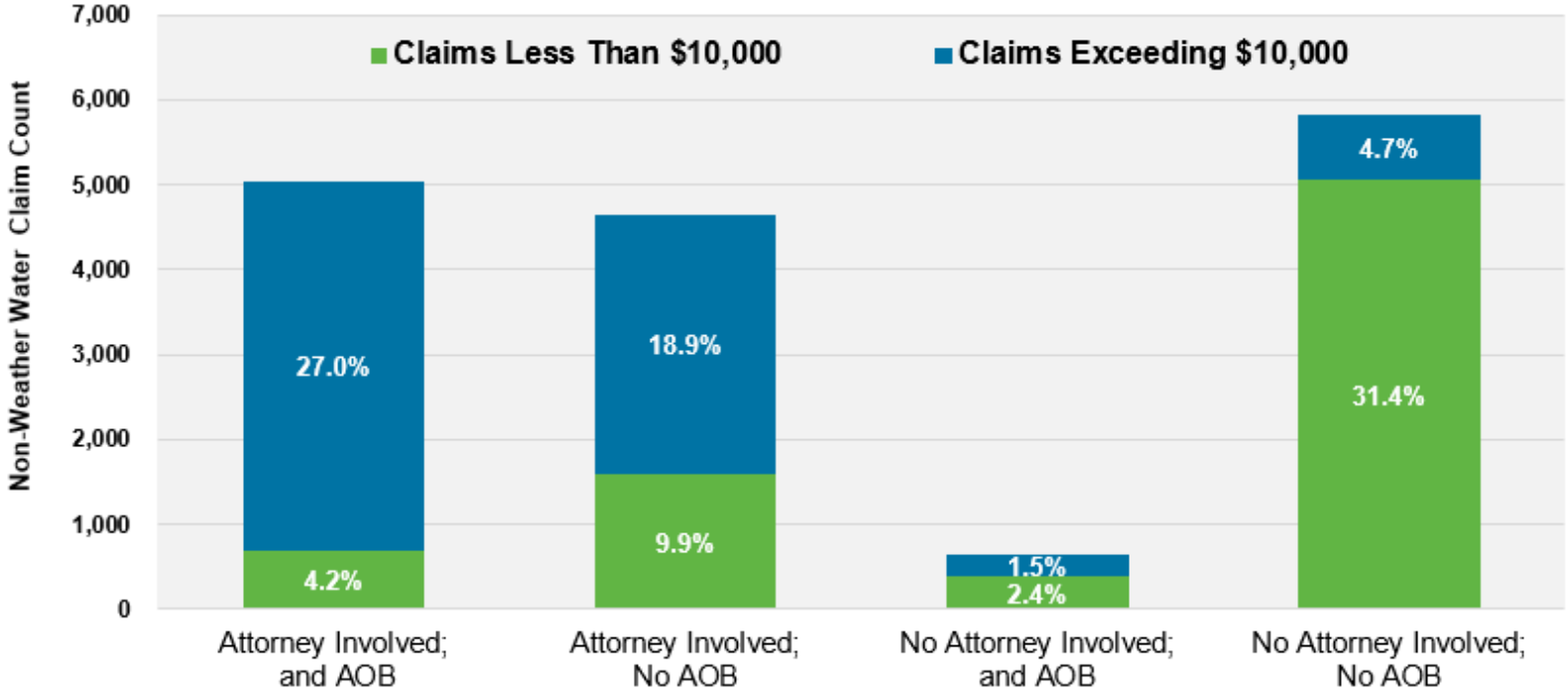


	Severity	# of Claims	% of Total
Attorney Involved; and AOB	$29,889	5,042	31.2%
Attorney Involved; No AOB	$21,269	4,644	28.8%
No Attorney Involved; and AOB	$9,530	636	3.9%
No Attorney Involved; No AOB	$4,430	5,828	36.1%
Average Non-Weather Water Claim	**$17,421**	**16,150**	**100.0%**

NOTES:

1) All claim information is based on HO-3 water claims closed between 1/1/2016 thru 6/30/2017
2) Attorney involvement is defined as a claim that was reported with representation and/or ended up in litigation

HO-3 Non-Weather Water Loss Data: $10,000 threshold



	Claims < $10,000				Claims > $10,000			
	Severity	# of Claims	% of < $10,000	% of Total	Severity	# of Claims	% of > $10,000	% of Total
Attorney Involved; and AOB	$3,996	684	8.8%	4.2%	$33,953	4,358	51.8%	27.0%
Attorney Involved; No AOB	$3,567	1,591	20.6%	9.9%	$30,494	3,053	36.3%	18.9%
No Attorney Involved; and AOB	$3,397	395	5.1%	2.4%	$19,584	241	2.9%	1.5%
No Attorney Involved; No AOB	$1,785	5,070	65.5%	31.4%	$22,120	758	9.0%	4.7%
Average Non-Weather Water Claim	**$2,429**	**7,740**	**100.0%**	**47.9%**	**$31,219**	**8,410**	**100.0%**	**52.1%**

NOTES:

1) All claim information is based on HO-3 water claims closed between 1/1/2016 thru 6/30/2017
2) Attorney involvement is defined as a claim that was reported with representation and/or ended up in litigation

MRP - Anticipated Impact on Premium Rates

In developing the 2018 premium rates, the impact of the program was taken into consideration:

Uncapped Indicated Premium Change		
County	Homeowners HO-3	
	2017	2018
Palm Beach	77.4%	17.0%
Broward	128.0%	42.5%
Miami-Dade	149.5%	46.2%
All Other Counties	6.4%	-3.8%
Statewide Total	**96.8%**	**30.0%**

The large reduction in the uncapped indicated premium rate change from 2017 to 2018 is directly related to the anticipated reduction in non-weather water losses from the new Managed Repair Program

NOTE: Citizens' premium rates are subject to a 10% cap on increases under the glide path to actuarial soundness. 2018 premium rates have not yet been set by the Florida Office of Insurance Regulation.

Conclusion

For Citizens' personal residential multi-peril policies, non-weather water losses are the current driver of higher premium rates

As a nonprofit entity, Citizens must pass on increased costs to our policyholders. With unchecked water losses, maximum rate increases will be applied to affected areas for many years to come.

This is no longer an isolated Palm Beach, Broward, and Miami-Dade county issue. Throughout the rest of the state (excluding Palm Beach, Broward, and Miami-Dade) the percentage of claims with AOB has grown from 1.9% in 2014 to 18.3% in 2017 YTD.

The goal of the Managed Repair Program is to provide quality service quickly so costly and time-consuming litigation is unnecessary

With the Managed Repair Program, Citizens projects that rather than receiving a decade of 10% rates increases in the tri-county area, policies could reach actuarially sound rates in as little as three years

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/7/17
Meeting Date

Bill Number (if applicable)

Topic Managed Repair Presentation

Amendment Barcode (if applicable)

Name Paul Handerhan

Job Title Consultant

Address 120 South Monroe Street
Street
Tallahassee FL 33021
City *State* *Zip*

Phone 561 704 0428

Email Paul@ambaconsult.com

Speaking: ☐ For ☐ Against ☒ Information

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

Representing FAPIA

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

Tuesday
11/7

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

—

Bill Number (if applicable)

Topic "Managed Repairs"

—

Amendment Barcode (if applicable)

Name Reggie Garcia

Job Title —

Address PO Box 11069 Phone 933-7150

Street

Tallahassee, FLA 32302 Email reggiegarcialaw@icloud.com

City State Zip

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against

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

Representing the Florida Justice Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

11-7-2017 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic INSURANCE - MANAGED REPAIR

Name CAM FENTRISS

Job Title LEGISLATIVE COUNSEL

Address 1400 VILLAGE SQUARE #3-243 (*Street*)

Phone 850-222-2772

TALLAHASSEE (*City*) FL (*State*) 32312 (*Zip*)

Email AFENTRISS@AOL.COM

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against

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

Representing FLA. ROOFING + SHEET METAL CONTRACTORS ASSN

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/7/2017
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Preferred Vendors

Name Mark Delegal

Job Title Retained Counsel

Address 315 S. Calhoun St #600
Street
Tallahassee FL 32301
City *State* *Zip*

Phone 224-7000

Email mark.delegal@hklaw.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing State Farm Mutual Automobile Ins Co.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11-7-17
Meeting Date

Bill Number (if applicable)

Topic Managed Repair

Amendment Barcode (if applicable)

Name Kate Hebrank (In place of Doug Buck)

Job Title

Address 113 East College Ave, Ste. 200
Street

Phone

City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Home Builders Assoc.

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/7/2017
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Managed Repair

Name Sandra Starnes

Job Title Director, P+C Product Review

Address 200 E. Gaines St.
Street

Tallahassee, FL 32399-0330
City *State* *Zip*

Phone 850-413-5344

Email Sandra.starnes@floir.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing FL Office of Insurance Regulation

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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11/07/17
Meeting Date

N/A
Bill Number (if applicable)

Topic Managed Repair Program

Amendment Barcode (if applicable)

Name Barry Gilway

Job Title President/CEO/Executive Director

Address
Street

Phone (850) 513.3757

Tallahassee FL
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Citizens Property Insurance Corporation

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/07/17
Meeting Date

Bill Number (if applicable)

Topic Managed Repair

Amendment Barcode (if applicable)

Name Dallas Trahern

Job Title Director of Operations & Carrier Relations, Entrusted

Address 945 West 15th Street
Street

Phone 561-966-0765

Rivera Beach | Florida | 33458
City | *State* | *Zip*

Email dallas.trahern@entrusted.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Association of Restoration Specialist

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/07/17
Meeting Date

Bill Number (if applicable)

Topic Managed Repair

Amendment Barcode (if applicable)

Name Alan Green

Job Title President, Green Construction Services & Ouick Dry Emergency Services

Address 3829 Progress Drive
Street

Phone 863-665-2767

Lakeland — Florida — 33811
City — *State* — *Zip*

Email alan@green-construction.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Association of Restoration Specialist

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

The Florida Senate

State Senator René García

36th District

Please reply to:

District Office:

1490 West 68 Street
Suite # 201
Hialeah, FL. 33014
Phone# (305) 364-3100

November 7, 2017

The Honorable Anitere Flores
Chairperson, Banking and Insurance
320 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Flores,

I will not be able to attend the Banking and Insurance Committee scheduled for today November 7, 2017 at 10:00am. Should you have any questions or concerns, please do not hesitate to contact my office.

Sincerely,

State Senator René García
District 36

CC: James Knudson
Sheri Green

CourtSmart Tag Report

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

Started: 11/7/2017 10:04:17 AM
Ends: 11/7/2017 11:59:58 AM Length: 01:55:42

10:04:29 AM quorum present
10:04:37 AM Sen Garcia is excused
10:04:43 AM 2 bills
10:04:49 AM Tab 2 SB 220 Sen Passidomo
10:05:15 AM Passidomo explains the bill
10:06:21 AM Chair Flores
10:06:44 AM Sen Thurston
10:06:54 AM Sen Passidomo responds
10:07:30 AM no further questions
10:07:38 AM in support
10:07:42 AM no debate
10:07:46 AM waive her close
10:07:58 AM Bill passes favorably
10:08:17 AM Tab 1 bill 98 by Sen Steube
10:08:31 AM Sen Steube explains the bill
10:08:52 AM Sen Flores
10:09:21 AM Senator Broxson with question
10:09:42 AM Sen Steube - died in House health policy committee
10:09:58 AM Sen Broxson
10:10:07 AM Sen Steube responds
10:10:32 AM Sen Broxson comments
10:10:46 AM Sen Flores opens for testimony
10:11:15 AM
10:11:48 AM Natalie Blake shares story of unavailable unauthorized medication at pharmacy
10:13:35 AM Natalie Blake is Director of Program & Services for Multiple Sclerosis Foundation in Ft. Lauderdale
10:14:57 AM Question from Sen Thurston
10:15:06 AM Ms. Blake responds
10:15:24 AM Sen Flores
10:15:59 AM Chris Nuland in support
10:16:02 AM Mary Thomas in support
10:16:03 AM Zayne Smith in support
10:16:08 AM Stephen Winn in support
10:16:13 AM Jill Gran in support
10:16:19 AM Cheryl Elias in support
10:16:33 AM Nicole Hill in support
10:16:35 AM Shuler in support
10:16:41 AM Laura in support
10:16:51 AM Audrey Brown
10:18:53 AM President and Ceo florida Associatio of Health---
10:19:34 AM Sen Thurston with question
10:19:41 AM Response from Ms Brown
10:20:09 AM Sen Thurston
10:20:13 AM Sen Flores in debate
10:20:24 AM no debate
10:20:29 AM Sen Steube closes
10:20:39 AM Sen Flores - call roll
10:20:49 AM Bill passess
10:21:08 AM Sen Flores - discussion on Managed Repair
10:21:23 AM
10:21:30 AM 2 presentations
10:21:52 AM Sen Flores explains discussion
10:22:34 AM Citizens Property Insurance Corporation and Fl Office of Insurance Regulation

10:23:03 AM Sandra Starnes Director of, P& C Product Review of FL Office of Insurance Regulation
10:23:40 AM Ms Starnes provides overview of what is used over the state of Florida
10:25:31 AM presentation explained
10:31:24 AM presentation explained
10:31:24 AM Senator Flores
10:31:29 AM Sen Broxson with question
10:31:40 AM Response from Ms. Starnes
10:32:48 AM Senator Flores
10:33:35 AM Starnes responds
10:33:42 AM Sen Flores
10:34:41 AM response from Starnes
10:34:48 AM Sen Bradley
10:35:12 AM Staff comments -
10:35:25 AM Starnes responds
10:35:36 AM Sen Flores
10:36:02 AM Response from Starnes
10:36:08 AM Senator Gaines
10:36:36 AM Response from Starnes
10:37:09 AM Senator Broxson comment
10:37:28 AM Sen Braynon with question
10:38:16 AM Starnes responds
10:38:50 AM Sen Braynon
10:39:01 AM Sen Thurston
10:39:09 AM Response from Starnes
10:39:51 AM Sen Bradley with question and comment
10:40:21 AM Starnes response
10:41:16 AM Sen Bradley continues
10:42:06 AM Starnes responds
10:42:51 AM Sen Bradley
10:42:59 AM Starnes responds
10:43:46 AM Sen Bradley questions
10:43:54 AM Starnes responds
10:44:55 AM Sen Bradley
10:44:59 AM Response from Starnes
10:46:16 AM Sen Bradley - does the Insured know who the vendor is at the time
10:46:51 AM Starnes -responds
10:47:06 AM Sen Bradley is there a public form?
10:47:19 AM Starnes responds
10:47:36 AM Sen Flores
10:48:36 AM Starnes responds
10:48:41 AM Sen Flores
10:49:18 AM Starnes
10:49:23 AM Sen Bradley - question - impact on rates?
10:49:41 AM Starnes response
10:50:10 AM Sen Flores
10:50:44 AM Senator Gainer with question
10:50:58 AM Response from Starnes
10:51:17 AM Sen flores
10:51:27 AM
10:52:14 AM Barry Gilway President CEO Executive Director of Citizens Property Insurance corporation
10:52:28 AM Citizens non - profit without an assessment
10:52:46 AM Affordability second concern from tri- county area across the state
10:53:14 AM Gilway expains the managed Repair program
10:53:42 AM Sen Bradley with question
10:53:49 AM Barry Gilmore with response
10:54:33 AM Sen Bradley with questions
10:54:51 AM Gilway responds
10:55:53 AM Sen Thurston with question
10:56:07 AM Gilway responds
10:57:03 AM Sen Thurston
10:57:13 AM Gilway responds
10:58:12 AM Sen Gainer with question

10:58:20 AM Gilway responds
11:00:38 AM Sen Broxson with question
11:00:53 AM Response from Gilway
11:01:23 AM Response from Gilway
11:01:23 AM Response from Gilway
11:01:23 AM Sen broxson
11:01:33 AM Gilway
11:01:36 AM Sen Broxson question
11:01:44 AM Gilway response
11:04:57 AM Sen Bradley with question
11:06:20 AM Gilway response
11:08:31 AM Sen Bradley with follow up
11:09:33 AM Gilway responds
11:12:10 AM Sen Bradley with follow u
11:12:47 AM Gilway responds
11:14:28 AM Sen thurston
11:16:20 AM Gilway responds
11:17:28 AM Sen thurston
11:17:32 AM Gilway with response
11:19:23 AM Sen Flores
11:20:25 AM Gilway continues with competitive programs - comment on deductable
11:23:18 AM Gilway proceeds with presentation
11:26:19 AM Sen Gainer with question
11:26:42 AM Gilway responds
11:28:38 AM Sen Gainer with question
11:29:51 AM Gilway responds
11:36:31 AM Sen Braynon
11:37:37 AM Gilway responds
11:38:14 AM Sen Flores comments
11:38:24 AM Gilway continues
11:41:26 AM Sen Flores
11:42:26 AM Gilway
11:42:33 AM Sen Broxson comments
11:43:46 AM Gilway response
11:44:28 AM Sen flores
11:44:32 AM Alan Green President of Green Construction Services & Quick Dry Emergency Services Lakela
11:50:02 AM Sen Flores
11:50:38 AM Sen Braynon
11:50:49 AM Mr. Green
11:52:31 AM Sen Flores
11:52:43 AM Dallas Trahern Director of operation & Carrier relations Entrusted
11:54:39 AM of Rivera Beach
11:58:47 AM Sen Flores
11:59:17 AM Sen Grimsley in affirmative for S 98 and 220
11:59:40 AM meeting adjourned