A bill to be entitled
An act relating to property and casualty insurance;
amending s. 627.062, F.S.; requiring the Office of
Insurance Regulation to use certain models or methods,
or a straight average of model results or output
ranges, to estimate hurricane losses when determining
whether the rates in a rate filing are excessive,
inadequate, or unfairly discriminatory; amending s.
627.0628, F.S.; increasing the length of time during
which an insurer is not required to adhere to certain
models found by the Commission on Hurricane Loss
Projection Methodology to be accurate or reliable in
determining probable maximum loss levels with respect
to certain rate filings; providing that the
requirement to adhere to such findings does not
prohibit an insurer from using a straight average of
model results or output ranges under specified
circumstances; amending s. 627.0651, F.S.; revising
provisions for the making and use of rates for motor
vehicle insurance; amending s. 627.3518, F.S.;
conforming a cross-reference; amending s. 627.4133,
F.S.; increasing the amount of prior notice required
with respect to the nonrenewal, cancellation, or
termination of certain insurance policies; deleting
certain provisions that require extended periods of
prior notice with respect to the nonrenewal,
cancellation, or termination of certain insurance
policies; prohibiting the cancellation of certain
policies that have been in effect for a specified
amount of time except under certain circumstances; amending s. 627.421, F.S.; authorizing a policyholder of personal lines insurance to affirmatively elect delivery of policy documents by electronic means; amending s. 627.7074, F.S.; revising notification requirements for participation in the neutral evaluation program; amending s. 627.736, F.S.; revising the period for applicability of certain Medicare fee schedules or payment limitations; amending s. 627.744, F.S.; revising preinsurance inspection requirements for private passenger motor vehicles; providing an effective date.

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

Section 1. Paragraph (b) of subsection (2) of section 627.062, Florida Statutes, is amended to read:

627.062 Rate standards.—

(2) As to all such classes of insurance:

(b) Upon receiving a rate filing, the office shall review the filing to determine whether a rate is excessive, inadequate, or unfairly discriminatory. In making that determination, the office shall, in accordance with generally accepted and reasonable actuarial techniques, consider the following factors:

1. Past and prospective loss experience within and without this state.

2. Past and prospective expenses.

3. The degree of competition among insurers for the risk
4. Investment income reasonably expected by the insurer, consistent with the insurer’s investment practices, from investable premiums anticipated in the filing, plus any other expected income from currently invested assets representing the amount expected on unearned premium reserves and loss reserves. The commission may adopt rules using reasonable techniques of actuarial science and economics to specify the manner in which insurers calculate investment income attributable to classes of insurance written in this state and the manner in which investment income is used to calculate insurance rates. Such manner must contemplate allowances for an underwriting profit factor and full consideration of investment income that produces a reasonable rate of return; however, investment income from invested surplus may not be considered.

5. The reasonableness of the judgment reflected in the filing.

6. Dividends, savings, or unabsorbed premium deposits allowed or returned to policyholders, members, or subscribers in this state.

7. The adequacy of loss reserves.

8. The cost of reinsurance. The office may not disapprove a rate as excessive solely due to the insurer having obtained catastrophic reinsurance to cover the insurer’s estimated 250-year probable maximum loss or any lower level of loss.

9. Trend factors, including trends in actual losses per insured unit for the insurer making the filing.

10. Conflagration and catastrophe hazards, if applicable.

11. Projected hurricane losses, if applicable, which must
be estimated using a model or method, or a straight average of
model results or output ranges, independently found to be
acceptable or reliable by the Florida Commission on Hurricane
Loss Projection Methodology, and as further provided in s.
627.0628.

12. Projected flood losses for personal residential
property insurance, if applicable, which may be estimated using
a model or method, or a straight average of model results or
output ranges, independently found to be acceptable or reliable
by the Florida Commission on Hurricane Loss Projection
Methodology and as further provided in s. 627.0628.

13. A reasonable margin for underwriting profit and
contingencies.

14. The cost of medical services, if applicable.

15. Other relevant factors that affect the frequency or
severity of claims or expenses.

The provisions of This subsection do not apply to workers’
compensation, employer’s liability insurance, and motor vehicle
insurance.

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

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

(3) ADOPTION AND EFFECT OF STANDARDS AND GUIDELINES.—

(d) With respect to a rate filing under s. 627.062, an
insurer shall employ and may not modify or adjust actuarial
methods, principles, standards, models, or output ranges found
by the commission to be accurate or reliable in determining hurricane loss factors for use in a rate filing under s. 627.062. An insurer shall employ and may not modify or adjust models found by the commission to be accurate or reliable in determining probable maximum loss levels pursuant to paragraph (b) with respect to a rate filing under s. 627.062 made more than 180 days after the commission has made such findings. This paragraph does not prohibit an insurer from using a straight average of model results or output ranges for the purposes of a rate filing for personal lines residential flood insurance coverage under s. 627.062.

Section 3. Subsection (8) of section 627.0651, Florida Statutes, is amended to read:

627.0651 Making and use of rates for motor vehicle insurance.—

(8) Rates are not unfairly discriminatory if averaged broadly among members of a group; nor are rates unfairly discriminatory even though they are lower than rates for nonmembers of the group. However, such rates are unfairly discriminatory if they are not actuarially measurable and credible and sufficiently related to actual or expected loss and expense experience of the group so as to ensure that nonmembers of the group are not unfairly discriminated against. Use of a single United States Postal Service zip code as a rating territory shall be deemed unfairly discriminatory unless filed pursuant to paragraph (1)(a) and such territory incorporates sufficient actual or expected loss and loss adjustment expense experience so as to be actuarially measurable and credible.
Section 4. Subsection (9) of section 627.3518, Florida Statutes, is amended to read:

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

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

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

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

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

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

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

2. If cancellation is for nonpayment of premium, at least 10 days’ written notice of cancellation accompanied by the reason therefor must be given. As used in this subparagraph, the term “nonpayment of premium” means failure of the named insured to discharge when due her or his obligations for paying the premium on a policy or an installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under a premium finance plan or extension of credit, or failure to maintain membership in an organization if such membership is a condition precedent to insurance coverage. The term also means the failure of a financial institution to honor an insurance applicant’s check after delivery to a licensed agent for payment of a premium even if the agent has previously delivered or transferred the premium to the insurer. If a dishonored check represents the initial premium payment, the contract and all contractual obligations are void ab initio unless the nonpayment is cured within the earlier of 5 days after actual notice by certified mail is received by the applicant or 15 days after notice is sent to the applicant by certified mail or registered mail. If the contract is void, any premium received by the insurer from a third party must be
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204 refunded to that party in full.

205 2. If cancellation or termination occurs during the first
206 90 days the insurance is in force and the insurance is canceled
207 or terminated for reasons other than nonpayment of premium, at
208 least 20 days’ written notice of cancellation or termination
209 accompanied by the reason therefor must be given unless there
210 has been a material misstatement or misrepresentation or a
211 failure to comply with the underwriting requirements established
212 by the insurer.

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

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

227 5. The requirement for providing written notice by June 1
228 of any nonrenewal that would be effective between June 1 and
229 November 30 does not apply to the following situations, but the
230 insurer remains subject to the requirement to provide such
231 notice at least 100 days before the effective date of
232 nonrenewal.
a. A policy that is nonrenewed due to a revision in the coverage for sinkhole losses and catastrophic ground collapse pursuant to s. 627.706.

5. b. A policy that is nonrenewed by Citizens Property Insurance Corporation, pursuant to s. 627.351(6), for a policy that has been assumed by an authorized insurer offering replacement coverage to the policyholder is exempt from the notice requirements of paragraph (a) and this paragraph. In such cases, the corporation must give the named insured written notice of nonrenewal at least 45 days before the effective date of the nonrenewal.

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

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

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

Section 6. Subsection (1) of section 627.421, Florida
Statutes, is amended to read:

627.421 Delivery of policy.—

(1) Subject to the insurer’s requirement as to payment of
premium, every policy shall be mailed, delivered, or
electronically transmitted to the insured or to the person
entitled thereto not later than 60 days after the effectuation
of coverage. Notwithstanding any other provision of law, an
insurer may allow a policyholder of personal lines insurance to
affirmatively elect delivery of the policy documents, including,
but not limited to, policies, endorsements, notices, or
documents, by electronic means in lieu of delivery by mail.
Electronic transmission of a policy for commercial risks,
including, but not limited to, workers’ compensation and
employers’ liability, commercial automobile liability,
commercial automobile physical damage, commercial lines
residential property, commercial nonresidential property,
farmowners insurance, and the types of commercial lines risks
set forth in s. 627.062(3)(d), constitutes delivery to the insured or to the person entitled to delivery
unless the insured or the person entitled to delivery
Section 7. Subsection (3) of section 627.7074, Florida Statutes, is amended to read:

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

(3) Following the receipt of the report provided under s. 627.7073 or the denial of a claim for a sinkhole loss, the insurer shall notify the policyholder of his or her right to participate in the neutral evaluation program under this section if there is coverage available under the policy and the claim was submitted within the timeframe provided in s. 627.706(5).

Neutral evaluation supersedes the alternative dispute resolution process under s. 627.7015 but does not invalidate the appraisal clause of the insurance policy. The insurer shall provide to the policyholder the consumer information pamphlet prepared by the department pursuant to subsection (1) electronically or by United States mail.

Section 8. Paragraph (a) of subsection (5) of section 627.736, Florida Statutes, is amended to read:

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

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

1. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:
   a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.
   b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital’s usual
and customary charges.

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

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

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

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

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

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

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

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

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

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

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

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

Section 9. Paragraphs (a) and (b) of subsection (2) of section 627.744, Florida Statutes, are amended to read:

627.744 Required preinsurance inspection of private passenger motor vehicles.—

(2) This section does not apply:

(a) To a policy for a policyholder who has been insured for 2 years or longer, without interruption, under a private passenger motor vehicle policy that provides physical damage coverage for any vehicle, if the agent of the insurer
(b) To a new, unused motor vehicle purchased or leased from a licensed motor vehicle dealer or leasing company, if the insurer may require is provided with:

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

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

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

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