Tab 2	**SB 312** by **Diaz**; (Compare to H 00017) Telehealth

Tab 3	**SB 468** by **Perry**; (Similar to H 00503) Insurance

868608	A	S	RS	BI, Perry	Delete L.470:	12/01 02:27 PM
951404	SA	S	RCS	BI, Perry	Delete L.470:	12/01 02:27 PM

Tab 4	**SB 546** by **Gruters**; (Similar to CS/H 00123) Consumer Finance Loans

Tab 5	**SB 838** by **Wright (CO-INTRODUCERS) Polsky, Hooper**; (Identical to H 00557) Fire Investigators

Tab 6	**SPB 7016** by **BI**; OGSR/Information Submitted by Insurers/Department of Financial Services

Tab 7	**SPB 7018** by **BI**; OGSR/Injured or Deceased Employee/Department of Financial Services

Tab 8	**SPB 7020** by **BI**; OGSR/Office of Insurance Regulation

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Boyd, Chair
Senator Broxson, Vice Chair

MEETING DATE: Wednesday, December 1, 2021
TIME: 8:30—11:00 a.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Boyd, Chair; Senator Broxson, Vice Chair; Senators Brandes, Burgess, Gruters, Passidomo, Rodrigues, Rouson, Stargel, Stewart, Taddeo, and Thurston

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Presentations on the Florida Birth-Related Neurological Injury Compensation Association		Presented
2	**SB 312** Diaz (Compare H 17)	Telehealth; Revising the definition of the term "telehealth"; narrowing the prohibition on prescribing controlled substances through telehealth to include only specified controlled substances, etc. HP 11/03/2021 Favorable BI 12/01/2021 Favorable RC	Favorable Yeas 10 Nays 0
3	**SB 468** Perry (Similar H 503)	Insurance; Redefining the term "covered policy" under the Florida Hurricane Catastrophe Fund in relation to certain collateral protection insurance policies; authorizing any association, trust, or pool created for the purpose of forming a risk management mechanism or providing self-insurance for a public entity to establish a quorum and conduct public business through communications media technology; authorizing insurers to file certain insurance rating plans based on certain windstorm mitigation construction standards, if certain requirements are met; authorizing insurers to file certain insurance rating plans based on certain windstorm mitigation construction standards, if certain requirements are met, etc. BI 12/01/2021 Fav/CS JU AP	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 546** Gruters (Similar H 123)	Consumer Finance Loans; Authorizing an applicant for a license to make and collect loans under the Florida Consumer Finance Act to provide certain documents in lieu of evidence of liquid assets; prohibiting a person licensed to make and collect consumer finance loans from charging prepayment penalties for loans; authorizing a licensee or an applicant for a license to make and collect consumer finance loans to provide a surety bond, certificate of deposit, or letter of credit in lieu of evidence of liquid assets; modifying grounds for denial of license or disciplinary action for certain violations of the Florida Consumer Finance Act, etc. BI 12/01/2021 Favorable CM RC	Favorable Yeas 11 Nays 0
5	**SB 838** Wright (Identical H 557)	Fire Investigators; Revising the definition of the term "firefighter" to include full-time, Florida-certified fire investigators for the purpose of expanding eligibility for certain cancer treatment benefits to include such investigators, etc. BI 12/01/2021 Favorable CA AP	Favorable Yeas 11 Nays 0
	Consideration of proposed bill:		
6	**SPB 7016**	OGSR/Information Submitted by Insurers/Department of Financial Services; Amending a provision which provides an exemption from public records requirements for certain information submitted by insurers to the Department of Financial Services; removing the scheduled repeal of the exemption, etc.	Submitted and Reported Favorably as Committee Bill Yeas 9 Nays 0
	Consideration of proposed bill:		
7	**SPB 7018**	OGSR/Injured or Deceased Employee/Department of Financial Services; Amending a provision which provides an exemption from public records requirements for the personal identifying information of an injured or deceased employee which is contained in reports, notices, records, or supporting documentation held by the Department of Financial Services pursuant to the Workers' Compensation Law; removing the scheduled repeal of the exemption, etc.	Submitted and Reported Favorably as Committee Bill Yeas 9 Nays 0
	Consideration of proposed bill:		

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SPB 7020**	OGSR/Office of Insurance Regulation; Amending a provision which provides an exemption from public records requirements for certain information held by the Office of Insurance Regulation relating to affiliated international trust entities; removing the scheduled repeal of the exemption; amending a provision which provides an exemption from public records requirements for certain information held by the office relating to qualified limited service affiliates; removing the scheduled repeal of the exemption; amending a provision which provides exemptions from public records requirements for certain information held by the office relating to active investigations of and the regulation of financial institutions; removing the scheduled repeal of the exemption, etc.	Submitted and Reported Favorably as Committee Bill Yeas 9 Nays 0

Other Related Meeting Documents

FLORIDA OFFICE OF Insurance Regulation

Florida Birth-Related Neurological Injury Compensation Association Market Conduct Operational Audit

FLORIDA OFFICE OF INSURANCE REGULATION

Susanne Murphy, Deputy Insurance Commissioner of Property and Casualty

December 1, 2021

Background and Scope

- The Florida Birth-Related Neurological Injury Compensation Association (NICA) was established by the Florida Legislature in 1988 to provide compensation for newborns with birth-related neurological injuries.
- In April 2021, the Department of Financial Services (DFS) requested that the Office of Insurance Regulation (OIR) conduct a Market Conduct Operational Audit to analyze NICA's claims handling practices and determine if NICA complied with its statutory mandate to finance medically necessary and reasonable care.
- The scope period of the audit was January 1, 2017 through December 31, 2020 and included the review of NICA's implementation of Senate Bill 1786 (2021).
- Auditors reviewed pertinent statutes, the NICA Plan of Operation, the 2013 Claims Manual, the 2020 Benefit Handbook, documents produced by NICA, and 10 sampled claims files, to conduct the audit.

Audit Findings & Recommendations

OIR's Market Conduct Operational Audit included **15 findings**. Generally, those findings can be grouped into five separate categories:

- Claims and Benefits Management
- Compliance with Florida Statutes
- Compliance with Plan of Operation
- Communication and Service to Participant Families
- Implementation of SB 1786

The audit identifies a number of areas that need improvement if NICA is to be in compliance with its statutory mandate outlined in section 766.303, F.S. to administer the plan in a manner that promotes and protects the health and best interest of children with birth-related neurological injuries.

OIR provided recommendations to the NICA Board of Directors for each of the 15 findings within the audit.

Findings & Recommendations

Finding 1: NICA's process for determining whether a treatment or benefit is medically necessary is inadequate.

- **Recommendation**: NICA's Board of Directors should develop and implement processes and procedures to ensure NICA's decisions regarding medical necessity are consistent and objectively applied.

Finding 2: NICA imposes monetary limits when reimbursing participant families for actual expenses that are not substantiated by documentation to support that the amount reimbursed represents the reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person as provided for in section 766.31(1)(c), F.S.

- **Recommendation**: NICA's Board of Directors should establish a process to ensure that the amounts reimbursed to participant families are substantiated and documented as the reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person, as established by Section 766.31(1)(c), F.S.

Findings & Recommendations Cont'd

Finding 3: NICA failed to properly document, in its claims system, claims denials or instances where claims or benefit inquiries submitted by participant families were not paid.

- **Recommendation**: NICA's Board of Directors should implement procedures to ensure that all instances where claims or benefit inquiries submitted by participant families, whether paid, unpaid or denied, are accurately documented in the claims system.

Finding 4: NICA's Benefit Disagreement process improperly forecloses participant families their right to file a petition with Division of Administrative Hearings (DOAH) to dispute the denial of a request for reimbursement, as provided for by section 766.31(1)(c), F.S.

- **Recommendation**: The Board of Directors should ensure the Benefit Disagreement process complies with section 766.31(1)(c), F.S. The Board of Directors should review the nature of all denied claims or claims without payment at regularly scheduled intervals to ensure participant families are provided with their statutory rights.

Findings & Recommendations Cont'd

Finding 5: NICA failed to record complaints received from participant families and failed to record if or how complaints are resolved.

- **Recommendation**: NICA's Board of Directors should implement procedures that define the term "complaint" and require NICA to record and retain records of complaints received from any source and the resolutions of those complaints to ensure proper documentation. The Board of Directors should consider implementing the use of an Ombudsman appointed to provide participant families with an avenue to voice concerns and to formally resolve conflicts. The Board of Directors should review the nature of all complaints received at regularly scheduled intervals to assess the effectiveness of the program and to determine if improvements to the program are needed.

Finding 6: NICA failed to maintain an outreach program to effectively communicate and assist participant families with information about compensation for actual expenses and other benefits available under the Plan.

- **Recommendation**: NICA's Board of Directors should implement a robust and continuous outreach and education program, including home visits, to assist participant families with accessing information about the Plan.

Findings & Recommendations Cont'd

Finding 7: NICA categorizes certain telephone or email communications received from participant families for requests for compensation to be "inquiries" because they were not a "complete claim."

- **Recommendation**: NICA's Board of Directors should conduct an in-depth review of all claims terminology utilized in the Plan of Operation, claims procedures manuals, benefit handbooks and by NICA's staff to ensure unambiguous and clearly defined claims terminology is provided to participant families.

Finding 8: NICA's 2020 Benefit Handbook, which is provided to participant family members upon receiving an award for compensation from DOAH, contains unclear and inconsistent instructions and guidelines.

- **Recommendation**: NICA's Board of Directors should review benefit handbooks and eliminate inconsistent instructions and guidelines.

Findings & Recommendations Cont'd

Finding 9: NICA's processes place barriers, burdens and time restrictions on participant families seeking reimbursement for actual expenses related to medically necessary and reasonable care for participant family members.

- **Recommendation**: NICA's Board of Directors should develop and implement meaningful and lasting program and process improvements to remove unnecessary barriers, burdens and time restrictions.

Finding 10: NICA's claims data is incomplete and unreliable.

- **Recommendation**: NICA's Board of Directors should ensure that NICA's claims system contains complete and accurate claims data.

Findings & Recommendations Cont'd

Finding 11: During the audit scope period, NICA failed to comply with Section 3.M. of NICA's Plan of Operation by failing to include specific payment procedures, a benefit schedule, and specific procedures to assure the timely and reasonable payment of claims in the claims procedures manual; by failing to develop and include a dispute resolution system in the claims procedures manual; and by failing to maintain or utilize an up to date claims procedures manual.

- **Recommendation**: The Board of Directors should ensure that NICA creates, and the Board approves an updated claims procedures manual that complies with Section 3.M. of the Plan of Operation and includes specific payment procedures, a benefit schedule and specific procedures to assure the timely and reasonable payment of claims.

Finding 12: NICA utilizes and reimburses certain third-party vendors without written contracts and does not utilize a competitive bid process to select third-party vendors.

- **Recommendation**: NICA's Board of Directors should ensure that NICA enters into written contracts with all third-party vendors and develops a general business practice of utilizing a competitive bid process for the selection of third-party vendors.

Findings & Recommendations Cont'd

Finding 13: NICA failed to maintain effective overall records management practices and a centralized, reliable records repository.

- **Recommendation**: NICA's Board of Directors should implement procedures to create and maintain a centralized, reliable, integrated, robust records management system.

Finding 14: The auditors were unable to verify the accuracy of NICA's reported number of participant families who are eligible to receive the additional $150,000 award following the implementation of Senate Bill 1786.

- **Recommendation**: NICA's Board of Directors should verify the accuracy of the reported number of participant families eligible to receive the additional $150,000 award.

Findings & Recommendations Cont'd

Finding 15: NICA failed to maintain accurate data related to participant families with deceased children and failed to timely issue the award for retroactive payments to participant families by July 1, 2021, as required by section 766.31(1)(d)2.b., F.S.

- **Recommendation**: NICA's Board of Directors should ensure that NICA maintains accurate and updated records for participant families. On an annual basis, NICA should utilize all means available to identify and locate eligible participant families and, only after exhausting all efforts and at the end of the required term, ensure the unpaid award is timely and accurately reported to DFS Bureau of Unclaimed Property.

Contact Information

David Altmaier, Commissioner
David.Altmaier@floir.com
(850) 413-3849

Mike Yaworsky, Chief of Staff
Mike.Yaworsky@floir.com
(850) 413-5000

Grant Phillips, Deputy Director of Government Affairs
Grant.Phillips@floir.com
(850) 413-2427

For more information visit www.floir.com.

A copy of the report is available on the OIR website https://floir.com/Sections/PandC/is_pc_exams.aspx.

NICA Market Conduct Operational Audit

Florida Office of Insurance Regulation

CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

October 18, 2021

Mr. Jim DeBeaugrine, Interim Chair
Board of Directors
Florida Birth-Related Neurological Injury Compensation Association
P. O. Box 14567
Tallahassee, FL 32302

Dear Chair DeBeaugrine:

Earlier this month, you were provided the Office of Insurance Regulation's (OIR) draft Market Regulation, Operational Audit, of the Florida Birth-Related Neurological Injury Compensation Association (NICA) program. You have since reviewed and accepted OIR's findings as submitted.

As you are aware, when issues regarding NICA came to light, I asked OIR to audit NICA to which they agreed and initiated this operational audit. The stories of parents, and their children, going through challenges in dealing with NICA were clearly symptomatic of a flawed program. That's why we needed OIR to take a look at the nuts-and-bolts of how NICA operates to determine where shortcomings existed.

The findings of this report are not be surprising and reaffirm many of the complaints families have publicly expressed. As a father of two, some of these findings boggle my mind and raise basic questions, such as why is a program of this size doing record keeping with CD-ROMs? Why are denials not documented? Plus, is there *any* process for figuring out whether a procedure, or a piece of equipment, is medically necessary or not? These are very basic elements of running a program of this type, and NICA was unable to provide auditors with acceptable answers.

With all of OIR's findings and recommendations, this report will provide the NICA Board with a roadmap for getting the trajectory of this organization headed on the right course. You have my full support in reforming this program so families are treated with the dignity and respect they deserve. Too often government can operate like a heartless bureaucracy and we cannot allow NICA to function with indifference. These families deserve nothing less than Florida's full compassion and support.

Sincerely,

Jimmy Patronis
Chief Financial Officer

October 18, 2021

The Honorable Jimmy Patronis
Chief Financial Officer
State of Florida
Florida Department of Financial Services
200 E. Gaines Street
Tallahassee, FL 32399-0301

SENT VIA EMAIL AND HAND DELIVERY

Re: Florida Birth-Related Neurological Injury Compensation Association (NICA) Market Conduct Operational Audit

Dear Chief Financial Officer Patronis:

The Florida Office of Insurance Regulation (OIR) has conducted a market conduct operational audit of the Florida Birth-Related Neurological Injury Compensation Association (NICA) pursuant to sections 624.3161 and 766.315(5)(d), Florida Statutes (F.S.), per your request.

The audit was conducted in close consultation with Florida's Insurance Consumer Advocate, Tasha Carter, to analyze NICA's claims handling practices and determine if NICA complied with its statutory mandate to finance the reimbursement of actual expenses incurred by participant family members for medically necessary and reasonable care.

Within the audit, OIR made 15 separate findings and provides recommendations to the NICA Board of Directors for each of these findings to administer the plan in a manner that promotes and protects the health and best interests of children with birth-related neurological injuries. The findings and recommendations are as follows:

- **Finding 1**: NICA's process for determining whether a treatment or benefit is medically necessary is inadequate.
    - Recommendation: NICA's Board of Directors should develop and implement processes and procedures to ensure NICA's decisions regarding medical necessity are consistent and objectively applied.

- **Finding 2**: NICA imposes monetary limits when reimbursing participant families for actual expenses that are not substantiated by documentation to support that the amount reimbursed represents the reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person as provided for in Section 766.31(1)(c), F.S.
    - Recommendation: NICA's Board of Directors should establish a process to ensure that the amounts reimbursed to participant families are substantiated and documented as the reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person, as established by Section 766.31(1)(c), F.S.
- **Finding 3**: NICA failed to properly document, in its claims system, claims denials or instances where claims or benefit inquiries submitted by participant families were not paid.
    - Recommendation: NICA's Board of Directors should implement procedures to ensure that all instances where claims or benefit inquiries submitted by participant families, whether paid, unpaid or denied, are accurately documented in the claims system.
- **Finding 4**: NICA's Benefit Disagreement process improperly forecloses participant families their right to file a petition with Division of Administrative Hearings (DOAH) to dispute the denial of a request for reimbursement, as provided for by Section 766.31(1)(c), F.S.
    - Recommendation: The Board of Directors should ensure the Benefit Disagreement process complies with Section 766.31(1)(c), F.S. The Board of Directors should review the nature of all denied claims or claims without payment at regularly scheduled intervals to ensure participant families are provided with their statutory rights.
- **Finding 5**: NICA failed to record complaints received from participant families and failed to record if or how complaints are resolved.
    - Recommendation: NICA's Board of Directors should implement procedures that define the term "complaint" and require NICA to record and retain records of complaints received from any source and the resolutions of those complaints to ensure proper documentation. The Board of Directors should consider implementing the use of an Ombudsman appointed to provide participant families with an avenue to voice concerns and to formally resolve conflicts. The Board of Directors should review the nature of all complaints received at regularly scheduled intervals to assess the effectiveness of the program and to determine if improvements to the program are needed.
- **Finding 6**: NICA failed to maintain an outreach program to effectively communicate and assist participant families with information about compensation for actual expenses and other benefits available under the Plan.

DAVID ALTMAIER • COMMISSIONER
200 EAST GAINES STREET • TALLAHASSEE, FLORIDA 32399-0305 • (850) 413-5914 • FAX (850) 488-3334
WEBSITE: WWW.FLOIR.COM • EMAIL: DAVID.ALTMAIER@FLOIR.COM

- Recommendation: NICA's Board of Directors should implement a robust and continuous outreach and education program, including home visits, to assist participant families with accessing information about the Plan.

- **Finding 7**: NICA categorizes certain telephone or email communications received from participant families for requests for compensation to be "inquiries" because they were not a "complete claim."
  - Recommendation: NICA's Board of Directors should conduct an in-depth review of all claims terminology utilized in the Plan of Operation, claims procedures manuals, benefit handbooks and by NICA's staff to ensure unambiguous and clearly defined claims terminology is provided to participant families.
- **Finding 8**: NICA's 2020 Benefit Handbook, which is provided to participant family members upon receiving an award for compensation from DOAH, contains unclear and inconsistent instructions and guidelines.
  - Recommendation: NICA's Board of Directors should review benefit handbooks and eliminate inconsistent instructions and guidelines.
- **Finding 9**: NICA's processes place barriers, burdens and time restrictions on participant families seeking reimbursement for actual expenses related to medically necessary and reasonable care for participant family members.
  - Recommendation: NICA's Board of Directors should develop and implement meaningful and lasting program and process improvements to remove unnecessary barriers, burdens and time restrictions.
- **Finding 10**: NICA's claims data is incomplete and unreliable.
  - Recommendation: NICA's Board of Directors should ensure that NICA's claims system contains complete and accurate claims data.
- **Finding 11**: During the audit scope period, NICA failed to comply with Section 3.M. of NICA's Plan of Operation by failing to include specific payment procedures, a benefit schedule, and specific procedures to assure the timely and reasonable payment of claims in the claims procedures manual; by failing to develop and include a dispute resolution system in the claims procedures manual; and by failing to maintain or utilize an up to date claims procedures manual.
  - Recommendation: The Board of Directors should ensure that NICA creates, and the Board approves an updated claims procedures manual that complies with Section 3.M. of the Plan of Operation and includes specific payment procedures, a benefit schedule and specific procedures to assure the timely and reasonable payment of claims.
- **Finding 12**: NICA utilizes and reimburses certain third-party vendors without written contracts and does not utilize a competitive bid process to select third-party vendors.
  - Recommendation: NICA's Board of Directors should ensure that NICA enters into written contracts with all third-party vendors and develops a general business practice of utilizing a competitive bid process for the selection of third-party vendors.

• • •

DAVID ALTMAIER • COMMISSIONER
200 EAST GAINES STREET • TALLAHASSEE, FLORIDA 32399-0305 • (850) 413-5914 • FAX (850) 488-3334
WEBSITE: WWW.FLOIR.COM • EMAIL: DAVID.ALTMAIER@FLOIR.COM

- **Finding 13**: NICA failed to maintain effective overall records management practices and a centralized, reliable records repository.
    - Recommendation: NICA's Board of Directors should implement procedures to create and maintain a centralized, reliable, integrated, robust records management system.
- **Finding 14**: The auditors were unable to verify the accuracy of NICA's reported number of participant families who are eligible to receive the additional $150,000 award following the implementation of Senate Bill 1786.
    - Recommendation: NICA's Board of Directors should verify the accuracy of the reported number of participant families eligible to receive the additional $150,000 award.
- **Finding 15**: NICA failed to maintain accurate data related to participant families with deceased children and failed to timely issue the award for retroactive payments to participant families by July 1, 2021, as required by section 766.31(1)(d)2.b., F.S.
    - Recommendation: NICA's Board of Directors should ensure that NICA maintains accurate and updated records for participant families. On an annual basis, NICA should utilize all means available to identify and locate eligible participant families and, only after exhausting all efforts and at the end of the required term, ensure the unpaid award is timely and accurately reported to DFS Bureau of Unclaimed Property.

Tasha Carter, Florida's Insurance Consumer Advocate, agrees with the findings and recommendations outlined in OIR's audit, which are consistent with her recommendations for the NICA Board of Directors. ICA Carter developed her recommendations following a series of meetings with NICA executive staff, feedback from participant families via a survey, direct communication with families and assisting families with specific inquiries. ICA Carter's recommendations are as follows:

- Establish and annually update written policies and procedures governing the operations of NICA, including, but not limited to:
    - The handling of claims and reimbursement requests
    - The determination of benefit eligibility and benefit disbursement
    - Parental nursing care guidelines
    - The collection of current and past due physician/mid-wife and hospital assessments and non-compliance reporting
- Revise the Claims Manual to accurately reflect current and improved claims handling procedures.
- Revise the Benefit Handbook to include all available benefits, including: a brief description of the benefit, the amount of the benefit, the required documentation to be submitted at the time the benefit request is made and if prior authorization is required. The Handbook should be updated and shared with families at least annually.

DAVID ALTMAIER • COMMISSIONER
200 EAST GAINES STREET • TALLAHASSEE, FLORIDA 32399-0305 • (850) 413-5914 • FAX (850) 488-3334
WEBSITE: WWW.FLOIR.COM • EMAIL: DAVID.ALTMAIER@FLOIR.COM

- Revise the Plan of Operations to accurately reflect current and improved operational procedures.
- Hire an Ombudsman who will act as an advocate for the parents and legal guardians of the NICA participant and report directly to the NICA Board of Directors.
- Modify the CARES System to streamline the claims and reimbursement process and reduce the administrative burden on NICA families and NICA. The modification should include the creation of a NICA family portal that will allow the uploading of claims and reimbursement requests, along with related documentation; automatic notification to the assigned nurse case manager that documents have been uploaded for review; the ability to document the status and resolution of the claim, including corresponding action dates and payment disbursement information; and the ability for the NICA parent or legal guardian to review the status of the claim at any time. NICA families would be provided with a secure login to access their individual portal.
- In addition to an electronic system update, provide a written denial on NICA letterhead for each claim or reimbursement request that is denied which includes an explanation and basis for the denial (reference to the relevant statute, section in the Plan of Operations, etc.).
- Establish written contracts with all third-party vendors. At a minimum, contracts should include a scope of work for services performed, the compensation amount, payment schedule and contract term. NICA should use a competitive bid process similar to the State of Florida's for the selection of third-party vendors.
- Perform a biennial review of all licensed vendors to verify license is active and in good standing.
- Provide an Explanation of Benefits quarterly to the parents and legal guardians of each NICA participant, including each benefit request, the amount and outcome. Families should also be able to download an EOB at any time from the updated CARES system.
- Create a comprehensive orientation program to orientate families that are new to NICA; including a comprehensive review of the Benefit Handbook, the Claims Manual, the Plan of Operations, written policies and procedures, an overview of the NICA Board and its purpose and all other pertinent information.
- Offer a variety of virtual informational sessions or informational resources on relevant programmatic topics to ensure NICA families are continuously educated and informed. NICA should solicit families for topic suggestions.
- Make available bilingual printed resources and bilingual staff to ensure effective communication with all NICA families.

• • •
DAVID ALTMAIER • COMMISSIONER
200 EAST GAINES STREET • TALLAHASSEE, FLORIDA 32399-0305 • (850) 413-5914 • FAX (850) 488-3334
WEBSITE: WWW.FLOIR.COM • EMAIL: DAVID.ALTMAIER@FLOIR.COM

Pursuant to section 624.319, Florida Statutes and Rule 69N-121.066, NICA was allotted 30 days to review and respond to the draft report prior to finalizing it. NICA responded within 10 days of receipt of the report with no suggestions to the draft and indicated the Board would use the recommendations as they move forward.

Sincerely,

David Altmaier
Insurance Commissioner

Tasha Carter
Florida's Insurance Consumer Advocate

CC: NICA Board of Directors Interim Chair, Jim DeBeaugrine

DAVID ALTMAIER • COMMISSIONER
200 EAST GAINES STREET • TALLAHASSEE, FLORIDA 32399-0305 • (850) 413-5914 • FAX (850) 488-3334
WEBSITE: WWW.FLOIR.COM • EMAIL: DAVID.ALTMAIER@FLOIR.COM

NICA SUPPORTIVE SERVICES FOR FAMILIES & PHYSICIANS

October 13, 2021

Ms. Sheryl Parker ARM, MCM
Director, Property and Casualty Market Regulation
Florida Office of Insurance Regulation
200 E. Gaines St.
Tallahassee, FL 32399

Dear Ms. Parker,

I have received the draft audit report on the Florida Birth Related Neurological Injury Compensation Association (NICA). NICA accepts the findings therein and does not request or recommend changes. We appreciate the effort your office put into the report. It will be a valuable resource to the Board and our management team as we seek to improve services for the children and families served by the organization.

Sincerely,

Jim DeBeaugrine, MPA
Interim Chair

THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION

MARKET REGULATION

OPERATIONAL AUDIT OF THE

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY

COMPENSATION ASSOCIATION

OCTOBER 1, 2021

BACKGROUND

The Florida Office of Insurance Regulation (OIR) conducted an operational audit (audit) of the Florida Birth-Related Neurological Injury Compensation Association (NICA) pursuant to Sections 624.3161 and 766.315(5)(d), Florida Statutes (F.S.) at the request of the Department of Financial Services (DFS). The scope period of the audit was January 1, 2017 through December 31, 2020 and included the review of NICA's implementation of certain legislative changes contained within Senate Bill 1786 (SB 1786) which became law on July 1, 2021.

NICA was established by the Florida Legislature in 1988 to administer the Florida Birth-Related Neurological Injury Compensation Plan (Plan). In part, the intent of the Legislature was to provide compensation, on a no-fault basis, for a limited class of newborns with birth-related neurological injuries. Participant family members and their parents or legal guardians give up their right to pursue other remedies as a condition of accepting benefits under the Plan, except in certain extreme cases, in accordance with Section 766.303(2), F.S.

With certain limitations, Section 766.31(1)(a), F.S. awards participant families with compensation for the actual expenses related to medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel for infants who sustain birth-related neurological injuries.

Section 766.31(1)(c), F.S. limits actual expenses to reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person and allows participant families receiving benefits under the Plan to file a petition with the Division of Administrative Hearing's (DOAH) administrative law judge to dispute the amount of actual expenses reimbursed or a denial of reimbursement.

During the audit's scope period, NICA was governed by a five-member Board of Directors.[1] Section 766.314(2)(a), F.S. requires NICA's Board of Directors to create and amend a Plan of Operation to ensure the efficient administration of the Plan and for the prompt processing of claims against and awards made on behalf of NICA. Sections 766.314(2)(a) and (b), F.S. require OIR to review and approve NICA's Plan of Operation or any amendments made by the Board of Directors. The original Plan of Operation was approved by the former Department of Insurance. Since 2003, when OIR was created, the Plan of Operation has been amended four times to update certain definitions, adopt amended statutory language or benefit changes, adopt new reporting requirements, and adopt amendments to processes related to investments and fund management. NICA's most current Plan of Operation was last approved by OIR on December 6, 2013.

NICA's Plan of Operation requires the Board of Directors to employ an Executive Director to serve as chief administrative staff person and to be responsible for the day-to-day operation of NICA. The Plan of Operation requires the Executive Director to develop a claims procedures manual to include payment procedures, a benefit schedule, a dispute resolution system, and other procedures to assure timely and reasonable payment of claims. The Board of Directors is required to approve the claims

[1] The composition of the Board of Directors was expanded to seven members in 2021 by Senate Bill 1786. The present members of NICA's Board of Directors were appointed after July 1, 2021 after the expiration of the audit's scope period.

procedures manual developed by the Executive Director. NICA's 2013 Claims Manual was the most current claims procedures manual in use at the time of the audit. During the audit, in addition to reviewing the pertinent statutes, the Plan of Operation, and the 2013 Claims Manual, the auditors reviewed NICA's 2020 Benefit Handbook, which is provided to participant family members upon receiving an award for compensation from DOAH. The auditors also reviewed documents produced by NICA and 10 sampled claims files representing a total of 2,064 lines of claims data.

The purpose of the audit was to analyze NICA's claims handling practices and determine if NICA complied with its statutory mandate to finance the reimbursement of actual expenses incurred by participant family members for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel by participant family members.

FINDINGS AND RECOMMENDATIONS

Finding 1: NICA's process for determining whether a treatment or benefit is medically necessary is inadequate.

In addition to the Executive Director, NICA employs one case manager supervisor and six case managers who, according to NICA's position descriptions, are responsible for analyzing and recommending the payment of claims and negotiating prices for medically necessary items. When a request for the reimbursement of actual expenses related to the care of a participant family member is received, NICA's case managers are responsible for making the initial determination of medical necessity, as stated in the 2013 Claims Manual. NICA stated the case managers and the case manager supervisor often use Google to research and determine medical necessity. In cases where medical necessity remains in question, NICA's process becomes dependent on a number of variables including who the assigned case manager is and the judgment of the Executive Director, who makes determinations regarding medical necessity regardless of the fact that she has no medical training or credentials. While the auditors noted that the case managers and case manager supervisor appear to have a wealth of overall nursing experience, NICA's position descriptions do not require them to have specific expertise in obstetrics or birth-related medical conditions.

There is no procedure requiring NICA to consult with a physician or other qualified medical professional in active practice of the same specialty or a process in place to ensure two or more staff members consistently arrive at the same conclusion to ensure that similarly situated participant family members are receiving substantially similar benefits[2].

Recommendation: NICA's Board of Directors should develop and implement processes and procedures to ensure NICA's decisions regarding medical necessity are consistent and objectively applied.

[2] Section 409.9131(2)(b), F.S. contains Florida Medicaid's definition for medical necessity or medically necessary.

Finding 2: NICA imposes monetary limits when reimbursing participant families for actual expenses that are not substantiated by documentation to support that the amount reimbursed represents the reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person as provided for in Section 766.31(1)(c), F.S.

NICA's 2020 Benefit Handbook and 2021 Quick Reference Benefits List contain a number of monetary benefit limits. A specific list of benefit limitations contained in NICA's 2020 Benefit Handbook are contained within Appendix A of this report; and a specific list of benefit limitations contained in NICA's 2021 Quick Reference Benefits List are contained within Appendix B of this report.

NICA was unable to provide any documentation to support the imposition of these monetary limits or that such limits complied with the provisions of Section 766.31(1)(c), F.S.

Recommendation: NICA's Board of Directors should establish a process to ensure that the amounts reimbursed to participant families are substantiated and documented as the reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person, as established by Section 766.31(1)(c), F.S.

Finding 3: NICA failed to properly document, in its claims system, claims denials or instances where claims or benefit inquiries submitted by participant families were not paid.

NICA provided the auditors with claims data relevant to the audit's scope period. Claims data is typically maintained in two categories: claims with payment and claims without payment. The auditors determined that NICA only maintains records related to paid claims or claims with payment but fails to code or document instances in the claims systems of unpaid expenses, denied claims, or instances where claims or inquiries for the compensation of actual expenses for participant family members were not reimbursed.

During the review of the 10 sampled claims files, the auditors identified the following instances where the claims notes reflected instances of denied claims that were not coded or recorded as denied claims in the claims system:

- One claims file contained evidence that NICA failed to fully reimburse a participant family's request for supplies. The claims file contained no information or justification for NICA's failure to reimburse for the requested supplies;

- One claims file contained evidence that NICA failed to reimburse a participant family for a hotel stay related to certain therapy treatments because no prior authorization was requested or approved before the scheduled therapy visit. The same claims file also reflects that NICA failed to reimburse the participant family for care hours during times when the participant family member received certain therapy treatments. The claims file documents that NICA later overturned the decision; and

- One claims file contained evidence that NICA initially denied reimbursement of claims for

a participant family member until the participant family submitted a significant amount of documentation to support medical necessity and initiated numerous follow up emails and telephone calls to NICA.

Recommendation: NICA's Board of Directors should implement procedures to ensure that all instances where claims or benefit inquiries submitted by participant families, whether paid, unpaid, or denied, are accurately documented in the claims system.

Finding 4: NICA's Benefit Disagreement process improperly forecloses participant families their right to file a petition with DOAH to dispute the denial of a request for reimbursement, as provided for by Section 766.31(1)(c), F.S.

The Benefit Disagreement section contained within the 2020 Benefit Handbook states that if there is a disagreement regarding an "eligible benefit," the issue is referred to a case manager supervisor. If the case manager supervisor is unable to resolve the dispute, the disagreement is referred to the Executive Director. If the disagreement remains unresolved, the participant can appeal to DOAH.

The language contained in the Benefit Disagreement section provides that the appeal process only applies to "eligible benefits" as defined and determined by NICA. Section 766.31(1)(c), F.S. provides participant families receiving benefits under the Plan with the right to file a petition with DOAH to dispute the amount of actual expenses reimbursed or a denial of reimbursement without regard to whether it is deemed an "eligible benefit" by NICA.

NICA confirmed that there is no formal procedure or process in place for providing participant family members with written denials. The statute does not require NICA to provide participant families with a written claims denial. The statute allows participant families receiving benefits under the Plan to dispute a denial of reimbursement. NICA confirmed that no participant family members have filed an appeal with DOAH since 2013.

Recommendation: The Board of Directors should ensure the Benefit Disagreement process complies with Section 766.31(1)(c), F.S. The Board of Directors should review the nature of all denied claims or claims without payment at regularly scheduled intervals to ensure participant families are provided with their statutory rights.

Finding 5: NICA failed to record complaints received from participant families and failed to record if or how complaints are resolved.

On April 6, 2017, a participant family testified in front of the Board of Directors stating in part, *"Change needs to happen in the NICA culture. It's an overwhelming system that literally takes YEARS to navigate. I implore you…Help families…don't put up brick walls…**Create a culture of trust and partnership.** I have many times over the past 16 or so years, felt NICA did not have a culture of being person-centered but denial driven."* In response to this testimony, the Chair of NICA's Board of Directors asked the Executive Director and staff to develop actionable steps to better address these concerns.

During the 2021 legislative session, several participant families voiced complaints and concerns related to the NICA program. One parent stated, "*I am hopeful now that there is legislation that is currently being drawn up to help families who are covered under NICA, so as to not have to jump through hoops and hell, to get the benefits that they rightly deserve for their children."*

Florida's Insurance Consumer Advocate and others conducted surveys throughout the course of 2021, the results of which contain valuable and meaningful feedback regarding both the positive and negative impacts of the NICA program on participant families.

NICA stated any complaint that has been received was resolved internally but NICA did not maintain or produce documentation to support the statement. NICA also stated without a definition or description of what a "complaint" is, it would be difficult for NICA to determine what should be maintained and how.

Recommendation: NICA's Board of Directors should implement procedures that define the term "complaint" and require NICA to record and retain records of complaints received from any source and the resolutions of those complaints to ensure proper documentation. The Board of Directors should consider implementing the use of an Ombudsman appointed to provide participant families with an avenue to voice concerns and to formally resolve conflicts. The Board of Directors should review the nature of all complaints received at regularly scheduled intervals to assess the effectiveness of the program and to determine if improvements to the program are needed.

Finding 6: NICA failed to maintain an outreach program to effectively communicate and assist participant families with information about compensation for actual expenses and other benefits available under the Plan.

Up until 2017, NICA made home visits to participant families after receiving an initial award for compensation from DOAH and periodically thereafter, when necessary. No similar replacement outreach efforts to support participant families have been instituted since 2017.

Recommendation: NICA's Board of Directors should implement a robust and continuous outreach and education program, including home visits, to assist participant families with accessing information about the Plan.

Finding 7: NICA categorizes certain telephone or email communications received from participant families for requests for compensation to be "inquiries" because they were not a "complete claim."

Section 766.305(4), F.S. uses but does not define the term "complete claim." This section of the statute is related to the initial claim for compensation under the Plan and not to requests for compensation of actual expenses related to medically necessary and reasonable care. Neither the term "inquiry" nor the term "complete claim" is defined in statute, the Plan of Operation, the 2013 Claims Manual, or the 2020 Benefit Handbook.

Recommendation: NICA's Board of Directors should conduct an in-depth review of all claims terminology utilized in the Plan of Operation, claims procedures manuals, benefit handbooks,

and by NICA's staff to ensure unambiguous and clearly defined claims terminology is provided to participant families.

Finding 8: NICA's 2020 Benefit Handbook, which is provided to participant family members upon receiving an award for compensation from DOAH, contains unclear and inconsistent instructions and guidelines.

- Page 5 of the 2020 Benefit Handbook advises participant family members that most benefits, except emergencies, should have NICA's prior approval before incurring expenses. However, NICA advised the auditors during the onsite interviews that, to receive payment, it must first be demonstrated that a participant family member "benefitted from" or noticeably "progressed" as a result of receiving a certain therapy or treatment;

- Page 17 of the 2020 Benefit Handbook provides that although a participant has been determined to be eligible for benefits, participant family members should contact NICA before committing to the purchase of equipment or incurring other expenses because failure to do so "may" jeopardize the amount of reimbursement; and

- Page 17 of the 2020 Benefit Handbook states NICA may not reimburse or may reimburse at a lower amount for benefits that the participant family member would be eligible for under an insurance policy or program when the parent or legal guardian refuses to seek those benefits. However, Sections 766.31(1)(a)2. and 4., F.S. state that expenses for items or services that the participant family member has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity and pursuant to the provisions of any health or sickness insurance policy or other private insurance program are not subject to compensation by NICA.

Recommendation: NICA's Board of Directors should review benefit handbooks and eliminate inconsistent instructions and guidelines.

Finding 9: NICA's processes place barriers, burdens, and time restrictions on participant families seeking reimbursement for actual expenses related to medically necessary and reasonable care for participant family members.

- NICA required parents to sign a Perjury Statement in order to receive the $150,000 parental award enacted under SB 1786, despite the legislation already providing eligibility criteria for participant families to receive the additional award. NICA discontinued this practice but only after it was disclosed during the audit;

- In cases where medical necessity was in question, NICA would only provide medical necessity forms directly to medical physicians and would not provide them to participant families even if requested. NICA also discontinued this practice after it was disclosed during the audit;

- Page 18 of the 2020 Benefit Handbook provides that if a participant family member receives treatment, evaluation or surgery outside of his insurance plan's coverage area, or outside of the state of Florida, NICA alone determines, in advance, whether it will elect to pay for those benefits, even if the treatment, evaluation or surgery is medically necessary; and

- Page 18 of the 2020 Benefit Handbook limits the time participant families are allowed to submit requests for reimbursement to one year from the date incurred, which is not required by Florida statutes.

Recommendation: NICA's Board of Directors should develop and implement meaningful and lasting program and process improvements to remove unnecessary barriers, burdens, and time restrictions.

Finding 10: NICA's claims data is incomplete and unreliable.

- The auditors were unable to ascertain the timely and accurate payment of claims because the claims system contains incomplete records of dates and lacks supporting documentation and related communications with participant families;

- NICA's claims system erroneously relabels participant family member claims numbers when claims data is exported into the reserves data;

- NICA's staff failed to accurately or consistently code all claims reimbursements in the claims system;

- NICA permitted staff members who sign payment authorizations for claims reimbursements to override the pre-authorization limits contained within the claims system; and

- NICA failed to provide accurate claims payment worksheets to the auditors. In three instances out of the 10 claims files reviewed, parental awards or plaintiff attorney fees or defense costs were not included in the claims payment worksheets. However, these payments were reflected in the claims system, requiring the auditors to compare the claims payments worksheets with the claims system to ensure a full and accurate review of the overall claims documentation.

Recommendation: NICA's Board of Directors should ensure that NICA's claims system contains complete and accurate claims data.

Finding 11: During the audit scope period, NICA failed to comply with Section 3.M. of NICA's Plan of Operation by failing to include specific payment procedures, a benefit schedule, and specific procedures to assure the timely and reasonable payment of claims in the claims procedures manual; by failing to develop and include a dispute resolution system in the claims procedures manual; and by failing to maintain or utilize an up to date claims procedures manual.

At the initiation of the audit, NICA provided its 2013 Claims Manual to the auditors in response to an information request for such documents. However, during the audit, NICA informed the auditors that the 2013 Claims Manual was outdated and no longer in use by NICA. No updated claims procedures manual has been developed or reviewed and approved by the Board of Directors since 2013.

Recommendation: The Board of Directors should ensure that NICA creates, and the Board approves, an updated claims procedures manual that complies with Section 3.M. of the Plan of Operation and includes specific payment procedures, a benefit schedule, and specific procedures to assure the timely and reasonable payment of claims.

Finding 12: NICA utilizes and reimburses certain third-party vendors without written contracts and does not utilize a competitive bid process to select third-party vendors.

NICA's claims system reflects that NICA reimbursed four medical opinion vendors $467,251.06 and one IT vendor $13,298.97 without written contracts during the audit scope period.

Recommendation: NICA's Board of Directors should ensure that NICA enters into written contracts with all third-party vendors and develops a general business practice of utilizing a competitive bid process for the selection of third-party vendors.

Finding 13: NICA failed to maintain effective overall records management practices and a centralized, reliable records repository.

The auditors visited NICA's offices in Tallahassee in May 2021 and observed boxes of paper records located throughout the offices. NICA utilizes CDs for some of its long-term storage, despite the fact that CDs can erode over time.

During the auditors' review of the sampled claims files, the auditors noted a significant number of documents were missing from the claims system and, in certain cases, were uploaded after NICA received an inquiry from the auditors. NICA stated that it had hired a third-party vendor to scan certain paper documents but was unable to provide an estimated completion date for this project.

Recommendation: NICA's Board of Directors should implement procedures to create and maintain a centralized, reliable, integrated, robust records management system.

IMPLEMENTATION OF SENATE BILL 1786

The scope of the operational audit included a review NICA's implementation of certain legislative changes contained within SB 1786, which was signed into law and became effective July 1, 2021.

Finding 14: The auditors were unable to verify the accuracy of NICA's reported number of participant families who are eligible to receive the additional $150,000 award.

Section 3 of SB 1786 amended Section 766.31(1)(d)1.b., F.S., awarding parents or legal guardians who received an award before January 1, 2021, and whose child currently receives benefits, to receive a retroactive payment in an amount sufficient to bring the total award to $250,000. As of August 6, 2021, NICA reported 215 families were determined to be eligible to receive the additional $150,000 award and that all families were paid as directed on or before June 30, 2021.

Of the 215 families:

- 170 were paid the full lump sum;
- 35 families requested the funds be "held;" and
- 16 families were paid "partial" benefits with the remainder held at the family's request.

The auditors were unable to verify the accuracy of the reported numbers which total 221 families, not the 215 families reported by NICA.

Recommendation: NICA's Board of Directors should verify the accuracy of the reported number of participant families eligible to receive the additional $150,000 award.

Finding 15: NICA failed to maintain accurate data related to participant families with deceased children and failed to timely issue the award for retroactive payments to participant families by July 1, 2021, as required by Section 766.31(1)(d)2.b., F.S.

Section 3 of SB 1786 also amended Section 766.31(1)(d)2.b., F.S., awarding parents or legal guardians who received an award and whose child died since the inception of the program, a retroactive payment in an amount sufficient to bring the total award paid to $50,000 which must be paid by July 1, 2021.

As of September 17, 2021, NICA reported that 206 families were determined to be eligible to receive the additional $40,000 award. Of the 206 families, 155 families have been paid. In the remaining instances:

- 50 families have not been paid because NICA did not maintain contact or up-to-date records for these family members; and

- 1 participant was identified as a ward of the state of Texas and multiple attempts to identify and contact a parent or legal guardian have gone unanswered.

The failure of NICA to maintain accurate data related to participant families prevented NICA from fulfilling its statutory obligation to issue an award for retroactive payments to those families.

NICA reported that it has hired a private detective and sent certified letters in an effort to locate and pay these families the remaining benefits. NICA also reported that it will turn all funds pertaining to non-responsive participant families over to the DFS Bureau of Unclaimed Property within the required timeframe[3].

[3] Chapter 717, F.S. requires unclaimed property assets to be held for a set period of time, usually five years.

Recommendation: NICA's Board of Directors should ensure that NICA maintains accurate and updated records for participant families. On an annual basis, NICA should utilize all means available to identify and locate eligible participant families and, only after exhausting all efforts and at the end of the required term, ensure the unpaid award is timely and accurately reported to DFS Bureau of Unclaimed Property.

CONCLUSION

This operational audit of NICA was designed to analyze the extent to which NICA's claims handling practices complied with its "statutory mandate to finance medically necessary and reasonable care, services, equipment, and travel for a limited class of catastrophic injuries for birth- related neurological injuries.[4]" This audit identifies a number of areas that need improvement if NICA is to be in compliance with its statutory mandate outlined in Section 766.303, F.S. "to administer the Plan in a manner that promotes and protects the health and best interest of children with birth-related neurological injuries.[5]" This audit report and the Findings are the result of a factual, data-driven analysis of NICA's claims handling practices.

[4] The Department of Financial Services (DFS) requested that OIR conduct an operational audit of NICA. The purpose of the audit was to focus on the extent to which NICA's claims handling practices complied with its statutory mandate to finance medically necessary and reasonable care, services, equipment, and travel for a limited class of catastrophic injuries for birth-related neurological injuries.

[5] SB 1786 added Section 766.303(4), F.S. which requires NICA to administer the Plan in a manner that promotes and protects the health and best interests of children with birth-related neurological injuries.

APPENDIX A

Benefit Limitations contained in NICA's 2020 Benefit Handbook[6]

Listed Benefit	Limitation Imposed
Equipment	• Equipment not provided includes jogging strollers and other equipment used solely for convenience or recreation which is not medically necessary.
Transportation Mileage	• Mileage for one trip to the pharmacy per month for prescriptions related to the participant family member's birth injury at a rate of $.23 per mile for gasoline if using a NICA provided van or $.445 per mile if using a privately owned vehicle. • Mileage for medical appointments or pre-approved travel at a rate of $.23 per mile if using a NICA provided van.
Travel	• Reimbursement for airline travel and meals for only one parent.
Handicapped Accessible Vans	• Participant family members must be 6 years of age or weigh 45 lb. • The cost of excess insurance coverage beyond "basic mandatory insurance plus comprehensive and collision." • Van replacement at 7 years or $150,000 miles. NICA reviews the vehicle's service history and may not replace the van if not properly maintained.
Augmentative Communication Technology	• Payment for reasonable repairs and replacement after 5 years.
Privately-Owned Housing Assistance & Total Lifetime Housing Benefit	• $30,000 one-time funding for modification to a non-rental home currently owned and occupied by the participant family. • NICA's construction manager or other qualified professional determines the feasibility of the modification and if the needs of the participant family member would be met in the contemplated project. • During the onsite interviews, the Executive Director also mentioned that this amount may be stipulated in the initial award issued by the administrative law judge.
Rental Housing Assistance	• NICA will reimburse the difference between the former monthly rental payment and the cost for an appropriate handicapped accessible rental unit of similar size and quality based on cost per square foot. • Substantial increases in square footage of the handicapped accessible unit must not exceed the overall guidelines utilized when NICA constructs additional space for a participant family member. • Up to $2,000 for qualified moving expenses for a one-time move to a handicapped accessible home or rental unit. The Plan may require certification of the rental unit's suitability prior to providing reimbursement.

[6] The amounts reflected are based on the language contained in the 2020 Benefit Handbook and do not reflect the amendments made to Florida statutes due to SB 1786 that became effective July 1, 2021.

Diapers	• Reimbursement begins at age 3.
Pureed Food	• Reimbursement begins at age 2. • Reimbursement amount is limited to $2.05 per jar or pouch for pre-processed baby food. • NICA encourages parent to use fresh foods and allows up to $500 to purchase a blender with a minimum 3-year replacement cycle. • The actual fresh food to be processed, including nuts, seeds, nutrients, and supplements are not eligible for reimbursement.
Insurance Premiums	• NICA "may" reimburse for the participant family member's portion of a health insurance premium on a prospective basis, only if reimbursement is requested. • NICA reserves the right to calculate the appropriate premium that will be reimbursed on a pro-rata basis.

APPENDIX B

Benefit Limitations contained in NICA's 2021 Quick Reference Benefits List[7]

Listed Benefit	Limitation Imposed
Annual Therapy Camp	• Limited to $2,000 per year
Augmentative Communication Technology	• Computer (limit $1,000 if no adaptive programs) • iPad (limit $500 if not adaptive programs)
Special Socks for AFOs, braces or other orthotics	• 4 pairs (duration not specified)
Shoes to fit with AFOs, braces or other orthotics	• 2 pairs per year
Guardianship costs	• One-time benefit up to $2,500
Electric Stipend	• $100 monthly amount to off-set additional electricity costs

[7] The amounts reflected are based on language contained in the 2021 Quick Benefits List and do not reflect the amendments made to Florida statutes due to SB 1786 that became effective July 1, 2021.

www.FLOIR.com

J. Edwin Larson Building
200 E. Gaines Street
Tallahassee, Florida 32399
Phone: (850) 413-3140

FLORIDA AUDITOR GENERAL

Florida Birth-Related Neurological Injury Compensation Association Audit Report No. 2022-009

Senate Banking and Insurance Committee

December 1, 2021

Background

- Section 766.303(1), Florida Statutes, establishes the Florida Birth-Related Neurological Injury Compensation Plan (Plan) to provide compensation, irrespective of fault, for neurological injury claims related to births occurring on or after January 1, 1989.
- Effective June 21, 2021, Chapter 2021-134, Laws of Florida, provided for the Plan to be governed by a seven-member Board of Directors (Board) appointed by the State's Chief Financial Officer and referred to as the Florida Birth-Related Neurological Injury Compensation Association (NICA). The NICA Board comprises one representative from each of the following groups: participating physicians, hospitals, casualty insurers, physicians other than participating physicians, the general public, a parent or legal guardian of a Plan participant and a representative of an advocacy organization for children with disabilities.

Audit Scope

- As required by Chapter 2021-134, Laws of Florida, the Auditor General conducted an operational audit of NICA that focused on NICA's administration of the Plan, including compliance with Sections 766.303 through 766.315, Florida Statutes, and applicable State public records and meetings laws.
- On August 13, 2021, the Auditor General issued operational audit report No. 2022-009 with 7 audit findings in the following areas:
  - Plan Administration
  - Assessments
  - Selected Administrative Activities
  - Information Technology Controls

Plan Administration

Pursuant to State law, claims for compensation commence by the claimant filing a petition with the Division of Administrative Hearings and, if a petition is approved by an Administrative Law Judge, the claimant becomes a participant in the Plan and is entitled to compensation awards for medically necessary and reasonable expenses, including hospital, habilitative and training, drugs, special equipment, facilities, and related travel.

Plan Administration

Finding 1: NICA had not established a mechanism to effectively and consistently document, account for, and track benefit denials or disputes.

Recommendation:

We recommend that NICA management enhance processes and controls to ensure that each participant claim for reimbursement is documented, accounted for, and tracked from initial request to resolution.

Plan Administration

Finding 2: Analysis of Plan participant survey responses indicated that the NICA *Benefit Handbook* could be enhanced to better inform participants of their benefits and rights and that NICA could take steps to ensure that benefit request decisions are documented and adequately explained to participants.

Plan Administration

Plan Participant Survey Results

	Dissatisfied		Satisfied		
	Number of Responses	Percentage of Responses	Number of Responses	Percentage of Responses	Total Number of Responses [a]
NICA *Handbook* was received.	12	11%	100	89%	112
NICA *Handbook* was adequate to understand rights and authorized benefits.	44	41%	63	59%	107
NICA timely and appropriately responded to Plan participant questions.	18	16%	92	84%	110
NICA's decisions on written exception requests were adequately explained.	18	42%	25	58%	43
Participant was satisfied with NICA's response to questions. [b]	26	26%	74	74%	100

[a] Not all 120 survey respondents provided responses to every question.

[b] Thirteen survey respondents indicated that they were neither satisfied nor dissatisfied with NICA's responses to questions.

Source: Survey responses from individuals listed by NICA as contacts for participants.

Recommendation:

We recommend that NICA management evaluate the NICA Handbook to ensure that participants are adequately informed of their benefits and rights and take steps to ensure that NICA participant benefit request decisions are documented and adequately explained to participants.

Plan Administration

Finding 3: NICA records did not always include the rationale for denying or limiting participant claim reimbursements.

Recommendation:

We recommend that NICA management ensure that the Handbook details all limitations on allowable reimbursement amounts and such limitations are appropriately communicated to participants. Additionally, we recommend that NICA management document the decision rationale each time a request for reimbursement is denied or limited.

NICA Assessments

- Section 766.314, Florida Statutes, authorizes NICA to collect annual assessments from physicians, certified nurse midwives, and hospitals to finance the Plan.
- During the period July 2019 through April 2021, the assessment was:
  - $250 per physician licensed in the State under Chapter 458 or 459, Florida Statutes.
  - $5,000 for physicians electing to participate in NICA.
  - $2,500 for certified nurse midwives working under the supervision of a certified physician.
  - $50 per live infant delivered at each hospital licensed under Chapter 395, Florida Statutes.
- According to NICA's audited financial statements, during the period July 2018 through June 2020, NICA collected assessments totaling $54,755,762.

Assessments

Finding 4: NICA did not timely or consistently use all available remedies to collect delinquent assessment amounts from non-participating physicians. As of June 16, 2021, active non-participating physicians owed NICA $14,367,193 for assessment amounts due for the 2016 through 2021 assessment years.

Assessments

Analysis of Active Non-Participating Physician Assessments Paid and Delinquent

For the 2016 Through 2021 Assessment Years

As of June 16, 2021

Assessment Year	Assessments Paid [a]		Delinquent Assessments		Total Assessment Amount	Delinquent Assessments as Percentage of Total Assessment Amount
	Amount	Number of Physicians	Amount	Number of Physicians		
2021	$13,791,926	56,362	$ 4,836,553	19,242	$ 18,628,479	26%
2020	16,035,537	64,372	3,118,420	12,043	19,153,957	16%
2019	16,209,715	65,209	2,291,303	8,336	18,501,018	12%
2018	16,132,917	64,487	1,765,173	6,123	17,898,090	10%
2017	16,159,869	64,043	1,356,025	4,506	17,515,894	8%
2016	14,486,458	58,316	999,719	3,215	15,486,177	6%
Totals	**$92,816,422**	**372,789**	**$14,367,193**	**53,465**	**$107,183,615**	**13%**

[a] Includes late payments and pre-payment amounts applicable to the assessment year.

Source: NICA records.

Recommendation:

We recommend that NICA management timely and consistently use all available remedies to collect delinquent assessment amounts.

Selected Administrative Activities

Finding 5: NICA expenses associated with holiday luncheons for NICA personnel did not appear to be clearly necessary to the performance of NICA's statutory duties. Additionally, meals provided for NICA personnel and Board members were not limited to the amounts provided by State law.

Selected Administrative Activities

- NICA hosted two holiday luncheons for NICA personnel in December 2019 and December 2020 with expenses totaling $363 and $421, respectively, that did not appear to be clearly necessary to the performance of NICA's statutory duties. Additionally, due to NICA's limited chart of accounts for general and administrative expenses, these expenses were recorded as travel. According to NICA management, these luncheons benefited the morale of NICA employees.
- NICA expended $1,145 on a breakfast buffet and $746 on all day non-alcoholic beverage passes for four Board members, two NICA personnel, and six others ($158 per person) who attended the August 26, 2019, Board meeting.

Selected Administrative Activities

- NICA expended $732 on a lunch buffet and $386 on all day non-alcoholic beverage passes for four Medical Advisory Committee members and three NICA personnel ($160 per person) who attended the September 28, 2019, NICA Medical Advisory Committee meeting. Additionally, due to NICA's limited chart of accounts, NICA recorded the meals as outreach.
- NICA expended $599 on a breakfast buffet and $399 on all day non-alcoholic beverage passes for three Board members, two NICA personnel, and seven others ($83 per person) who attended the December 13, 2019, Board meeting.
- Contrary to State law, the *Procedures Manual* permitted NICA personnel to be reimbursed or to charge a NICA-issued credit card at the State reimbursement rate, or the reasonable actual work-related cost, for pre-approved travel. The *Procedures Manual* stated that, without a receipt, meals would be paid at a rate of $6, $11, and $19 for breakfast, lunch, and dinner, respectively. Consequently, our examination noted that 13 NICA personnel meal expenses, totaling $1,046, exceeded State reimbursement rates.

Selected Administrative Activities

Recommendation:

We recommend that NICA management:

- *Ensure that the totality and nature of general and administrative expenses are clearly necessary to the performance of NICA's administration of the Plan and that the NICA chart of accounts promotes the appropriate recording of expenses.*
- *Limit expenses for Board and Medical Advisory Committee meetings to those clearly necessary to discharge Board and Committee duties and to the amounts authorized by State law.*
- *Update the Procedures Manual to require that reimbursable meal expenses and meals charged to a NICA-issued credit card not exceed statutorily authorized reimbursement rates.*

Selected Administrative Activities

Finding 6: NICA controls did not promote the retention of text and instant messages in accordance with State public records laws.

Recommendation:

We recommend that NICA management enhance mobile device controls to ensure that all text and instant messages sent or received by NICA-owned mobile devices are retained in accordance with State law.

Information Technology Controls

Finding 7: Certain security controls related to user authentication for the network domain, NICA virtual private network (VPN), and Claims Accounting and Reserves Electronic System need improvement to ensure the confidentiality, integrity, and availability of NICA data and information technology resources.

Recommendation:

We recommend that NICA management improve certain security controls related to user authentication for the network domain, NICA VPN, and CARES to ensure the confidentiality, integrity, and availability of NICA data and related IT resources.

Joshua Barrett, CPA
Audit Manager

111 West Madison Street

Tallahassee, FL 32399-1450

(850) 412-2804

joshuabarrett@aud.state.fl.us

FLAuditor.gov

STATE OF FLORIDA AUDITOR GENERAL

Operational Audit

Report No. 2022-009
August 2021

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION

Sherrill F. Norman, CPA
Auditor General

Board of Directors and Executive Director of the Florida Birth-Related Neurological Injury Compensation Association

Section 766.303, Florida Statutes, establishes the Florida Birth-Related Neurological Injury Compensation Plan (Plan) to provide compensation, irrespective of fault, for neurological injury claims related to births occurring on or after January 1, 1989. During the period of our audit, Section 766.315(1)(a), Florida Statutes, provided for the Plan to be governed by a five-member Board of Directors appointed by the State's Chief Financial Officer and referred to as the Florida Birth-Related Neurological Injury Compensation Association (NICA). The NICA Board comprises one representative from each of the following groups: participating physicians, hospitals, casualty insurers, physicians other than participating physicians, and the general public.

During the period of our audit, Kenney Shipley served as the Executive Director of NICA and the following individuals served as Board members:

Representing:	**Board Member:**
General Public	Charles Lydecker, Chair
Participating Physicians	Steven Dukes, M.D.
Hospitals	Bryan Anderson
Casualty Insurers	Robert E. White, Jr.
Non-Participating Physicians	Samuel Wolf, D.O., from October 9, 2020 Marcos Lorenzo, M.D., through October 8, 2020

The team leader was Christi Alexander, CPA, and the audit was supervised by Joshua Barrett, CPA.

Please address inquiries regarding this report to Joshua Barrett, CPA, Audit Manager, by e-mail at joshuabarrett@aud.state.fl.us or by telephone at (850) 412-2804.

This report and other reports prepared by the Auditor General are available at:

FLAuditor.gov

Printed copies of our reports may be requested by contacting us at:

State of Florida Auditor General

Claude Pepper Building, Suite G74 · 111 West Madison Street · Tallahassee, FL 32399-1450 · (850) 412-2722

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION

SUMMARY

This operational audit of the Florida Birth-Related Neurological Compensation Association (NICA) focused on NICA's administration of the Florida Birth-Related Neurological Compensation Plan (Plan), including NICA's compliance with Sections 766.303 through 766.315, Florida Statutes, and applicable State public records and meetings laws. The audit also included an examination of selected NICA administrative activities. Our audit disclosed the following:

Plan Administration

Finding 1: NICA had not established a mechanism to effectively and consistently document, account for, and track benefit denials or disputes.

Finding 2: Analysis of Plan participant survey responses indicated that the NICA *Benefit Handbook* could be enhanced to better inform participants of their benefits and rights and that NICA could take steps to ensure that benefit request decisions are documented and adequately explained to participants.

Finding 3: NICA records did not always include the rationale for denying or limiting participant claim reimbursements.

NICA Assessments

Finding 4: NICA did not timely or consistently use all available remedies to collect delinquent assessment amounts from non-participating physicians. As of June 16, 2021, active non-participating physicians owed NICA $14,367,193 for assessment amounts due for the 2016 through 2021 assessment years.

Selected Administrative Activities

Finding 5: NICA expenses associated with holiday luncheons for NICA personnel did not appear to be clearly necessary to the performance of NICA's statutory duties. Additionally, meals provided for NICA personnel and Board members were not limited to the amounts provided by State law.

Finding 6: NICA controls did not promote the retention of text and instant messages in accordance with State public records laws.

Information Technology Controls

Finding 7: Certain security controls related to user authentication for the network domain, NICA virtual private network (VPN), and Claims Accounting and Reserves Electronic System need improvement to ensure the confidentiality, integrity, and availability of NICA data and information technology resources.

BACKGROUND

State law[1] establishes the Florida Birth-Related Neurological Injury Compensation Plan (Plan) to provide compensation, irrespective of fault, for neurological injury claims related to births occurring on or after January 1, 1989. State law[2] defines a "birth-related neurological injury" as an injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth, caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. The definition applies to live births only and does not include disability or death caused by genetic or congenital abnormality.

The Plan was governed by a five-member Board of Directors (Board) appointed by the State's Chief Financial Officer and referred to as the Florida Birth-Related Neurological Injury Compensation Association (NICA). The NICA Board comprises one representative from each of the following groups:[3]

- Participating physicians.
- Hospitals.
- Casualty insurers.
- Physicians other than participating physicians.
- The general public.

NICA is not considered a State agency, board, or commission.

FINDINGS AND RECOMMENDATIONS

PLAN ADMINISTRATION

State law[4] specifies that an administrative law judge (ALJ) with the Division of Administrative Hearings (DOAH) has exclusive jurisdiction to determine whether a claim filed with NICA is compensable. State law further specifies that no civil action may be brought until a compensability decision has been made by an ALJ. Claims for compensation commence by the claimant filing a petition with DOAH and, if a petition is approved by an ALJ, the claimant becomes a participant in the Plan and entitled to compensation awards for medically necessary and reasonable expenses, including hospital, habilitative and training, drugs, special equipment, facilities, and related travel. However, compensation is not to be provided for expenses related to items or services that the infant has received or is entitled to receive, or expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, from any prepaid health plan, health maintenance organization, or other

[1] Section 766.303(1), Florida Statutes.

[2] Section 766.302(2), Florida Statutes.

[3] Section 766.315, Florida Statutes. Pursuant to Chapter 2021-134, Laws of Florida, effective June 21, 2021, the number of Board members was increased to seven by adding a parent or legal guardian of a Plan participant and a representative of an advocacy organization for children with disabilities. A listing of 2021 statutory changes impacting NICA are included as ***EXHIBIT A*** to this report.

[4] Section 766.304, Florida Statutes.

private insuring entity. In addition, compensation is not to be provided for expenses for items or services that the infant has received, or is entitled to receive, or expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by Federal law.[5]

Compensation also includes periodic payments of an award to the infant's parents or legal guardians not to exceed $100,000, a $10,000 death benefit, and reasonable expenses incurred in connection with the filing of a claim, including attorney's fees.[6] According to NICA records, during the period July 2019 through April 2021, 435 participants were reimbursed for claims totaling $38,555,837.

Finding 1: Benefit Denial and Dispute Records

NICA's responsibilities include administering the Plan and the payment of claims on behalf of the Plan. Once a claimant becomes a participant in the Plan, a case manager is assigned to analyze benefit requests and to determine whether a request fits the medical profile and statutory requirements. Case managers are responsible for ensuring that Plan participants timely receive a *Benefit Handbook* (*Handbook*) that outlines participant rights, allowable expenses, benefit information, and procedures for filing reimbursement claims and benefit disputes.

Once a claim is determined to be compensable by an ALJ, NICA communicates with the parents or legal guardians of the participant to determine the medically necessary and reasonable needs of the participant and family. The *Handbook* includes a listing of benefits and procedures established to carry out NICA's statutory duties and specifies that NICA pays benefits under the Plan based on an evaluation of each participant and their needs. The *Handbook* further specifies that, if a parent or legal guardian feels that a benefit not described in the *Handbook* would be of advantage to the participant, the parent or legal guardian may request, by letter, that the benefit be reviewed by the Executive Director of NICA as an exception. The *Handbook* also provides that, when a Case Manager Supervisor cannot resolve a benefits dispute, the Executive Director is to attempt to resolve the dispute with the parent or legal guardian. The *NICA Claims Manual* (*Claims Manual*) for case managers provides that participants should be made aware of alternative methods of dispute resolution other than through legal channels so that the participants will come to their case manager before taking legal action on a claim.

NICA created the Claims Accounting and Reserves Electronic System (CARES), a Web-based system, to track participant activity, such as ALJ orders, participant contact information, and claims for reimbursement. As part of our audit, we interviewed NICA management and examined NICA records to determine whether NICA had established effective controls over claims processing, including approvals, denials, and benefit disputes. Our audit procedures found that, while NICA had established procedures for benefit denials and disputes, NICA had not established a mechanism within CARES to effectively and consistently document, account for, and track benefit denials or disputes from initial claims request to

[5] Section 766.31(1)(a), Florida Statutes.

[6] Section 766.31(1)(b) and (c), Florida Statutes. Pursuant to Chapter 2021-134, Laws of Florida, beginning January 1, 2021, periodic payments of an award may not exceed $250,000 and parents and guardians who received an award prior to January 1, 2021, and whose child currently receives benefits are to receive a retroactive payment sufficient to bring the total award paid to $250,000. Chapter 2021-134, Laws of Florida, also increased the death benefit to $50,000. A listing of 2021 statutory changes impacting NICA are included as ***EXHIBIT A*** to this report.

resolution. Specifically, we noted that, as of May 18, 2021, CARES accounted for and tracked approved and paid claims through a combination of the paid check or Automated Clearing House number assigned to a participant's claim number. However, NICA had not established unique identifiers to account for and track denied or disputed claims.

According to NICA management, the case manager was to log requests into CARES, and include in the Activity Log, correspondence and supporting records related to potential denials or benefit disputes. NICA management further indicated that NICA does not provide participants formal denials of benefit requests. Instead, according to NICA, the CARES Activity Log may show that participants did not provide sufficient information or did not respond to requests for additional information that would facilitate the processing of a request or that NICA found acceptable alternatives for the participants.

Notwithstanding management's response, given the limitations of CARES, these outcomes were not always readily apparent. Additionally, with NICA's reliance on alternative dispute and benefit resolution methods, including those involving the Executive Director, it is important that NICA establish a mechanism to document, account for, and track the handling of all claims from initial request to resolution to evidence that claims are appropriately considered and adjudicated in accordance with State law and NICA procedures. According to NICA management, NICA was in the process of determining how to capture information that would allow NICA to effectively track the outcome of all claims for reimbursement, from initial request to resolution.

Recommendation: We recommend that NICA management enhance processes and controls to ensure that each participant claim for reimbursement is documented, accounted for, and tracked from initial request to resolution.

Finding 2: NICA Plan Participant Survey

To measure the degree of Plan participant satisfaction, in May 2021 we surveyed the 279 individuals listed as contacts for the 221 participants active in the Plan as of April 30, 2021. Survey questions, listed in ***EXHIBIT B*** to this report, addressed participant satisfaction with the *Handbook*, explanation of benefits, NICA's handling of questions, and the dispute resolution process.

We received survey responses from 120 respondents and the survey responses, as summarized in Table 1, indicated that most of the respondents received the *Handbook* and were satisfied with NICA's responses to participant questions. However, 41 percent of the respondents expressed dissatisfaction with the explanation of benefits and participant rights provided in the *Handbook* and 42 percent expressed dissatisfaction with the adequacy of NICA's explanation for the decision to approve or deny participant exception requests. Some respondents indicated that many covered items were not listed in the *Handbook* and that participants were not always made aware of what benefits to request. Additionally, respondents indicated that NICA did not always clearly explain, either verbally or in writing, why a benefit request was denied.

Table 1
Plan Participant Survey Results

	Dissatisfied		Satisfied		
	Number of Responses	Percentage of Responses	Number of Responses	Percentage of Responses	Total Number of Responses [a]
NICA *Handbook* was received.	12	11%	100	89%	112
NICA *Handbook* was adequate to understand rights and authorized benefits.	44	41%	63	59%	107
NICA timely and appropriately responded to Plan participant questions.	18	16%	92	84%	110
NICA's decisions on written exception requests were adequately explained.	18	42%	25	58%	43
Participant was satisfied with NICA's response to questions. [b]	26	26%	74	74%	100

[a] Not all 120 survey respondents provided responses to every question.

[b] Thirteen survey respondents indicated that they were neither satisfied nor dissatisfied with NICA's responses to questions.

Source: Survey responses from individuals listed by NICA as contacts for participants.

Recommendation: We recommend that NICA management evaluate the NICA *Handbook* to ensure that participants are adequately informed of their benefits and rights and take steps to ensure that NICA participant benefit request decisions are documented and adequately explained to participants.

Finding 3: Claims Reimbursement

For each reimbursement request, the case manager is to determine and document medical necessity, its relationship to the injury, and rule out other payment sources. In addition to the *Handbook*, the *Claims Manual* provided guidance to case managers when reviewing and approving or denying participant requests for reimbursement.

As part of our audit, we reviewed the *Handbook* and *Claims Manual* for consistency and alignment with statutorily allowable costs. Additionally, we examined NICA records, including the CARES Activity Logs, for 25 participant claim reimbursements, totaling $150,251, paid during the period July 2019 through April 2021, to determine whether NICA appropriately documented approved and denied requests for reimbursement. We noted that:

- State law[7] specifies that a telehealth provider[8] has the duty to practice in a manner consistent with their scope of practice and the prevailing professional standard of practice for a health care professional who provides in-person health care services to a patient in the State. Effective March 20, 2020, the Agency for Healthcare Administration (AHCA) issued an alert expanding the use of telemedicine during the COVID-19 pandemic for Florida Medicaid. NICA received a copy of the AHCA alert on March 24, 2020. However, our examination of the CARES Activity Logs and participant records found that, on March 24, 2020, and March 26, 2020, NICA denied two participant requests for reimbursement of physical therapy telehealth services. In both

[7] Section 456.47(2)(a), Florida Statutes.

[8] Section 456.47(1)(b), Florida Statutes, defines a telehealth provider as any individual who provides health care and related services using telehealth and who is licensed or certified pursuant to State law.

instances, NICA records did not evidence how the expenses were not medically necessary and reasonable or that NICA had requested from the participants letters of medical necessity for the telehealth services. We also noted that a subsequent request for telehealth services from one of the two participants in November 2020 was approved.

In response to our audit inquiry, NICA management indicated that, at the time of the March 2020 requests, NICA had not established guidelines for the reimbursement of physical or occupational therapy telehealth services. Absent a letter of medical necessity from the service provider indicating that telehealth was to be used, it was difficult for NICA to determine how the physical evaluation and participant movements could be accomplished by telehealth. On November 18, 2020, NICA management informed case managers that NICA was going to cover physical and occupational therapy telehealth services. In response to our audit inquiry, NICA management indicated that they were not aware of any out-of-pocket expenses incurred by participants for these services.

- NICA records did not evidence the rationale for limiting a reimbursement request for a computer used as augmentative communication technology to $1,000, instead of the total $1,314 cost incurred by the participant. According to NICA management, NICA reimbursed the claim using guidelines included in draft revisions to the *Handbook* that detail reimbursement limitations for computers without any adaptive programs or attachments.

Absent records evidencing the basis for denying or limiting a participant reimbursement request and the *Handbook* reflecting current policy, NICA cannot adequately demonstrate that the Plan is being equitably administered in accordance with State law.

Recommendation: We recommend that NICA management ensure that the *Handbook* details all limitations on allowable reimbursement amounts and such limitations are appropriately communicated to participants. Additionally, we recommend that NICA management document the decision rationale each time a request for reimbursement is denied or limited.

NICA ASSESSMENTS

State law[9] authorizes NICA to collect annual assessments from physicians, certified nurse midwives, and hospitals to finance the Plan. During the period July 2019 through April 2021, the assessment per physician licensed in the State under Chapter 458 or 459, Florida Statutes, was $250. Physicians electing to participate in NICA were assessed $5,000, certified nurse midwives working under the supervision of a certified physician were assessed $2,500, and each hospital[10] licensed under Chapter 395, Florida Statutes, was assessed $50 per live infant delivered[11] at the hospital during the prior calendar year. According to NICA's audited financial statements, during the period July 2018 through June 2020, NICA collected assessments totaling $54,755,762.

[9] Section 766.314, Florida Statutes.

[10] Section 766.314(4)(a), Florida Statutes, excludes hospitals owned or operated by the State or county, special taxing district, or other political subdivision of the State from assessment requirements.

[11] Section 766.314(4)(a), Florida Statutes, specifies that hospitals may exclude any infant born to a charity patient or born to a patient for whom the hospital receives Medicaid reimbursement, if the sum of the annual charges for charity patients plus annual Medicaid contractuals of the hospital exceeds 10 percent of the total annual gross operating revenues of the hospital.

Finding 4: Delinquent Assessments

State law[12] specifies that NICA may file suit to enforce the collection of required assessments and is entitled to attorney's fees, costs, and interest paid upon the entry of judgment against a physician for failure to pay. As part of the assessment process, NICA receives a listing of licensed physicians and hospitals from the Department of Health and AHCA, respectively. NICA sends billing statements to hospitals[13] and non-participating physicians[14] each October with the notification that, if payment is not received by January 1, NICA will charge interest at the statutorily authorized rate.[15] NICA's assessment on non-participating physicians is considered a tax[16] subject to the 5-year statute of limitation to take action to collect any tax.[17]

To evaluate whether NICA had established effective controls to ensure the timely collection of statutorily authorized assessments, we interviewed NICA management, analyzed NICA billing and payment records for hospitals and non-participating physicians, and examined NICA records for 40 non-participating physicians with assessment amounts due by January 1, 2020 and 2021, and 40 hospitals with assessment amounts due by January 1, 2021. Our audit procedures found that while NICA included interest charges on the billing statements of non-participating physicians with delinquent assessment amounts, NICA did not consistently take additional actions, such as sending demand collection letters or filing suit in county court, to ensure the collection of delinquent assessment amounts. According to NICA management, NICA had not sent demand collection letters since September 2017 and last filed suit in county court in January 2018 due to the substantial time and cost associated with the collection process and that NICA typically filed suit in batches covering multiple years to defray such costs. As shown in Table 2, our analysis of assessment data for active non-participating physicians disclosed that, as of June 16, 2021, the physicians' delinquent assessment amounts for the 2016 through 2021 assessment years totaled $14,367,193, representing approximately 13 percent of the total assessment amount for those years.

[12] Section 766.314(6)(b), Florida Statutes.

[13] Hospital billing statements are provided for the prior year based on hospital live birth records.

[14] Non-participating physician billing statements are for the upcoming assessment year. For example, the October 2020 billing statement was for the 2021 assessment year.

[15] Section 55.03, Florida Statutes, provides for the Chief Financial Officer to set the applicable rate of interest.

[16] James F. Coy, M.D. v. Florida Birth-Related Neurological Injury Compensation Plan, 595 So.2d 943, Supreme Court of Florida.

[17] Section 95.091(1)(a), Florida Statutes.

Table 2
Analysis of Active Non-Participating Physician Assessments Paid and Delinquent
For the 2016 Through 2021 Assessment Years
As of June 16, 2021

Assessment Year	Assessments Paid [a]		Delinquent Assessments		Total Assessment Amount	Delinquent Assessments as Percentage of Total Assessment Amount
	Amount	Number of Physicians	Amount	Number of Physicians		
2021	$13,791,926	56,362	$ 4,836,553	19,242	$ 18,628,479	26%
2020	16,035,537	64,372	3,118,420	12,043	19,153,957	16%
2019	16,209,715	65,209	2,291,303	8,336	18,501,018	12%
2018	16,132,917	64,487	1,765,173	6,123	17,898,090	10%
2017	16,159,869	64,043	1,356,025	4,506	17,515,894	8%
2016	14,486,458	58,316	999,719	3,215	15,486,177	6%
Totals	**$92,816,422**	**372,789**	**$14,367,193**	**53,465**	**$107,183,615**	**13%**

[a] Includes late payments and pre-payment amounts applicable to the assessment year.

Source: NICA records.

To ensure that all statutorily authorized assessment amounts due to NICA to support the Plan are collected, it is critical that NICA consistently and timely use all available remedies to collect delinquent amounts.

Recommendation: We recommend that NICA management timely and consistently use all available remedies to collect delinquent assessment amounts.

Follow-Up to Management's Response

NICA management indicated in their written response that they disagreed with the $14.4 million total cited in the finding as the amount of outstanding non-participating physician assessments for the 2016 through 2021 assessment years. Instead, NICA management estimated the total for non-exempt, outstanding assessments to be closer to $8.4 million. However, as indicated in management's response, management based their figure on an estimate of physicians exempt from the statutory assessment. At the time of our audit, documentation identifying the physicians who were exempt from paying the assessment was not available. Consequently, the finding and recommendation stand as presented.

SELECTED ADMINISTRATIVE ACTIVITIES

As part of our audit, we evaluated selected NICA administrative activities and controls, including those related to general and administrative expenses and mobile devices.[18]

[18] Mobile devices are portable devices, such as laptop computers, smartphones, and tablets, that allow storage and transmittal of entity data.

Finding 5: NICA Expenses

State law[19] specifies that funds collected by NICA and any income therefrom are to be disbursed only for the payment of awards for compensation and for the reasonable expenses of administering the Plan. State law[20] authorizes travel paid by a public agency[21] to be reimbursed at a rate of $80 per travel day ($20 per quarter of the travel day), or if actual expenses exceed $80 per day, the actual expenses for lodging plus $6, $11, and $19 for breakfast, lunch, and dinner, respectively. State law[22] provides that Board members are to be reimbursed at the statutorily authorized reimbursement rates for actual and necessary expenses incurred in the performance of their official duties as a Board member of the Plan.

To determine whether NICA expenses served an authorized public purpose and were clearly necessary to the performance of NICA's statutory duties, we interviewed NICA management, reviewed the *NICA Personnel Policies and Procedures Manual* (*Procedures Manual*), and examined NICA records for 97 general and administrative expense transactions totaling $705,150 and incurred during the period July 2019 through April 2021. Our audit procedures found that:

- NICA hosted two holiday luncheons for NICA personnel in December 2019 and December 2020 with expenses totaling $363 and $421, respectively, that did not appear to be clearly necessary to the performance of NICA's statutory duties. Additionally, due to NICA's limited chart of accounts for general and administrative expenses, these expenses were recorded as travel. According to NICA management, these luncheons benefited the morale of NICA employees.
- While in travel status, NICA Board members and personnel were provided meals that exceeded the allowances authorized by State law. Specifically, we found that:
    - NICA expended $1,145 on a breakfast buffet and $746 on all day non-alcoholic beverage passes for four Board members, two NICA personnel, and six others ($158 per person) who attended the August 26, 2019, Board meeting.
    - NICA expended $732 on a lunch buffet and $386 on all day non-alcoholic beverage passes for four Medical Advisory Committee[23] members and three NICA personnel ($160 per person) who attended the September 28, 2019, NICA Medical Advisory Committee meeting. Additionally, due to NICA's limited chart of accounts, NICA recorded the meals as outreach.
    - NICA expended $599 on a breakfast buffet and $399 on all day non-alcoholic beverage passes for three Board members, two NICA personnel, and seven others ($83 per person) who attended the December 13, 2019, Board meeting.
    - Contrary to State law, the *Procedures Manual* permitted NICA personnel to be reimbursed or to charge a NICA-issued credit card at the State reimbursement rate, or the reasonable actual work-related cost, for pre-approved travel. The *Procedures Manual* stated that, without a receipt, meals would be paid at a rate of $6, $11, and $19 for breakfast, lunch, and dinner, respectively. Consequently, our examination noted that 13 NICA personnel meal expenses,

[19] Section 766.314(3), Florida Statutes.

[20] Section 112.061(6), Florida Statutes.

[21] Section 112.061(2)(a), Florida Statutes, defines an agency or public agency as any office, department, agency, division, subdivision, political subdivision, board, bureau, commission, authority, district, public body, body politic, county, city, town, village, municipality, or any other separate unit of government created pursuant to law.

[22] Section 766.315(3), Florida Statutes.

[23] NICA created the Medical Advisory Committee to provide recommendations regarding medical evaluations and procedures utilized to evaluate claimants for inclusion in the Plan and to provide recommendations for treatment policies for participants with complex medical issues.

totaling $1,046, exceeded statutorily authorized reimbursement rates. For example, two NICA personnel charged $82 ($41 per person) to a NICA-issued credit card for dinner the evening before the September 28, 2019, Medical Advisory Committee meeting.

According to NICA management, due to the number of attendees (e.g., Board and Medical Advisory Committee members, NICA personnel, investment consultants, actuaries, auditors), NICA contracted in advance with the hotel to have a buffet set up in the meeting room to allow the meetings to continue without breaking for meals. Further, NICA management indicated that NICA personnel, Board and Committee members, and other attendees were not reimbursed for meals when food was provided as part of the meeting. Notwithstanding, the average cost per person exceeded the meal allowances authorized by State law.

As stewards of funds intended to provide compensation for birth-related neurological injuries that result in significant medical and other costs, NICA management is responsible for ensuring that expenses are authorized by and in accordance with applicable law, reasonable in the circumstances and necessary to accomplish the authorized purpose of NICA and Board, and in pursuit of public, rather than a private, purpose.

Recommendation: We recommend that NICA management:

- **Ensure that the totality and nature of general and administrative expenses are clearly necessary to the performance of NICA's administration of the Plan and that the NICA chart of accounts promotes the appropriate recording of expenses.**
- **Limit expenses for Board and Medical Advisory Committee meetings to those clearly necessary to discharge Board and Committee duties and to the amounts authorized by State law.**
- **Update the *Procedures Manual* to require that reimbursable meal expenses and meals charged to a NICA-issued credit card not exceed statutorily authorized reimbursement rates.**

Finding 6: Retention of Text and Instant Messages

State law[24] requires agencies[25] to maintain public records in accordance with the records retention schedule[26] established by the Department of State, Division of Library and Information Services. The schedule specifies that the retention periods for electronic communications, including text and instant messages, are based on the content, nature, and purpose of the messages. Some of the purposes include administrative correspondence (3 fiscal years), program and policy development correspondence (5 fiscal years), and transitory messages (until obsolete, superseded, or administrative value is lost). According to NICA records, as of May 3, 2021, 19 NICA-owned mobile devices, including 2 Apple devices, were approved to conduct NICA business and had text and instant messaging capabilities.

To evaluate NICA's administration of mobile devices, we interviewed NICA management and inspected records for the 19 NICA-owned mobile devices. We noted that NICA had not disabled text messaging nor established a method to capture and retain text messages sent or received by the 19 NICA-owned

[24] Section 119.021(2)(b), Florida Statutes.

[25] Section 119.011(2), Florida Statutes, defines an agency as any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law.

[26] State of Florida *General Records Schedule GS1-SL for State and Local Government Agencies*.

mobile devices. Our examination of all NICA mobile device invoices for the period July 4, 2019, through May 3, 2021, found that 1,101 text messages were sent or received by 16 of the NICA-owned mobile devices. Additionally, we noted that NICA had not disabled instant messaging (iMessages) on the two NICA Apple devices nor established a method to capture and retain iMessages sent or received by these devices. According to NICA management, 17 of the mobile devices were provided to personnel to enable remote work during the COVID-19 pandemic and that NICA was researching methods to ensure that all text and instant messages are captured and retained in accordance with State law. Additionally, NICA management indicated that, as of June 11, 2021, iMessages had been disabled on the two Apple devices.

Absent a method to adequately retain text and instant messages, such messages may be sent or received and not be retained in accordance with State law, diminishing transparency and NICA's ability to provide access to public records.

Recommendation: We recommend that NICA management enhance mobile device controls to ensure that all text and instant messages sent or received by NICA-owned mobile devices are retained in accordance with State law.

INFORMATION TECHNOLOGY CONTROLS

As part of our audit, we evaluated selected NICA information technology (IT) controls, including controls related to user authentication.

Finding 7: Security Controls – User Authentication

Security controls are intended to protect the confidentiality, integrity, and availability of data and IT resources. Our audit procedures disclosed that certain security controls related to user authentication for the network domain, NICA VPN, and CARES need improvement. We are not disclosing the specific details of the issues in this report to avoid the possibility of compromising NICA data and related IT resources. However, we have notified appropriate NICA management of the specific issues.

Without appropriate security controls related to user authentication for the network domain, NICA VPN, and CARES, the risk is increased that the confidentiality, integrity, and availability of NICA data and related IT resources may be compromised.

Recommendation: We recommend that NICA management improve certain security controls related to user authentication for the network domain, NICA VPN, and CARES to ensure the confidentiality, integrity, and availability of NICA data and related IT resources.

RELATED INFORMATION

As part of our audit, we interviewed NICA management and NICA's general counsel regarding potential litigation. In response to our audit inquiries, NICA provided the pleadings and orders for Arven v. the Florida Birth-Related Neurological Injury Compensation Association and Florida Birth-Related Neurological Injury Compensation Plan, Case No. 19-cv-61053, in the Southern District of Florida; Case No. 20-13448, in the Eleventh Circuit Court of Appeals.

On September 9, 2019, the Plaintiffs/Relators filed an amended complaint alleging that NICA violated the Federal False Claims Act ("FCA"), 31 U.S.C. § 3729 *et seq.*, because NICA does not pay for expenses covered by Medicaid as the primary payor. The complaint asserted that the *Handbook* declares that NICA is the payor of last resort and that the Plan pays after available insurance or governmental programs have paid for medically necessary and reasonable expenses. In the Relators' view, NICA is a "third party" under 42 U.S.C. § 1396a(a)(25)(A) and, as such, NICA should pay for expenses that would otherwise be covered by Medicaid because Medicaid is the "payor of last resort." The Plaintiffs/Relators seek treble damages civil penalties and attorneys' fees and costs for damages to the United States. On January 30, 2020, the United States notified the District Court that it would not intervene, but would continue its investigation.

On February 26, 2020, NICA filed a motion to dismiss the amended complaint arguing that: the Plan lacks capacity to be sued and, in any event, the amended complaint failed to state a claim against the Plan; as an arm of the State, NICA cannot be held liable under the FCA; the Relators' claims fail under the Public Disclosure Bar; NICA is not a "third party" under 42 U.S.C. § 1396a(a)(25)(A); the amended complaint fails to allege a knowing violation; and the amended complaint does not identify any false claims or unpaid obligations.

On September 8, 2020, the United States District Court, Southern District of Florida, issued an order denying the motion to dismiss. In issuing the order, the District Court found that NICA is a third party and not an arm of the State and that sufficient circumstantial assertions were available to satisfy the knowledge element at this stage of the proceeding.

On December 20, 2020, NICA filed an opening brief with the United States Eleventh Circuit Court of Appeals requesting that the September 8, 2020, District Court order be reversed and the case be remanded to the District Court with instructions to dismiss with prejudice. As of June 1, 2021, the appeal is pending.

In response to our audit inquiry, NICA management indicated that the litigation of the issues bearing on a favorable or unfavorable outcome remains ongoing. As a result, the likelihood of a particular outcome cannot be reasonably made at this time, and a potential range of loss or recovery cannot be currently stated to a reasonable degree of certainty.

OBJECTIVES, SCOPE, AND METHODOLOGY

The Auditor General conducts operational audits of governmental entities to provide the Legislature, Florida's citizens, public entity management, and other stakeholders unbiased, timely, and relevant information for use in promoting government accountability and stewardship and improving government operations.

We conducted this operational audit from May 2021 through June 2021 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This operational audit of the Florida Birth-Related Neurological Injury Compensation Association (NICA) focused on NICA's administration of the Florida Birth Related Neurological Compensation Plan (Plan), including NICA's compliance with Sections 766.303 through 766.315, Florida Statutes, and applicable State public records and meetings laws. The audit also included an examination of selected administrative activities. For those areas, the objectives of the audit were to:

- Evaluate management's performance in establishing and maintaining internal controls, including controls designed to prevent and detect fraud, waste, and abuse, and in administering responsibilities in accordance with applicable laws, administrative rules, contracts, grant agreements, and other guidelines.
- Examine internal controls designed and placed into operation to promote and encourage the achievement of management's control objectives in the categories of compliance, economic and efficient operations, the reliability of records and reports, and the safeguarding of assets, and identify weaknesses in those internal controls.
- Identify statutory and fiscal changes that may be recommended to the Legislature pursuant to Section 11.45(7)(h), Florida Statutes.

This audit was designed to identify, for those programs, activities, or functions included within the scope of the audit, deficiencies in internal controls significant to our audit objectives; instances of noncompliance with applicable governing laws, rules, or contracts; and instances of inefficient or ineffective operational policies, procedures, or practices. The focus of this audit was to identify problems so that they may be corrected in such a way as to improve government accountability and efficiency and the stewardship of management. Professional judgment has been used in determining significance and audit risk and in selecting the particular transactions, legal compliance matters, records, and controls considered.

As described in more detail below, for those programs, activities, and functions included within the scope of our audit, our audit work included, but was not limited to, communicating to management and those charged with governance the scope, objectives, timing, overall methodology, and reporting of our audit; obtaining an understanding of the program, activity, or function; identifying and evaluating internal controls significant to our audit objectives; exercising professional judgment in considering significance and audit risk in the design and execution of the research, interviews, tests, analyses, and other procedures included in the audit methodology; obtaining reasonable assurance of the overall sufficiency and appropriateness of the evidence gathered in support of our audit's findings and conclusions; and reporting on the results of the audit as required by governing laws and auditing standards.

Our audit included the selection and examination of transactions and records. Unless otherwise indicated in this report, these transactions and records were not selected with the intent of statistically projecting the results, although we have presented for perspective, where practicable, information concerning relevant population value or size and quantifications relative to the items selected for examination.

An audit by its nature, does not include a review of all records and actions of agency management, staff, and vendors, and as a consequence, cannot be relied upon to identify all instances of noncompliance, fraud, abuse, or inefficiency.

In conducting our audit, we:

- Reviewed applicable laws and NICA policies and procedures and interviewed NICA personnel to obtain an understanding of NICA Plan processes.

- Interviewed NICA management and compared the NICA *Benefit Handbook* (*Handbook*) and the *NICA Claims Manual* (*Claims Manual*) to applicable laws to determine whether the *Handbook* and *Claims Manual* were designed in a manner that effectively assisted participants when filing claims for reimbursement, informed participants of their rights, and assisted NICA case managers when reviewing participant claims for reimbursement.
- To measure NICA Plan participant satisfaction, sent surveys to the 279 individuals listed as contacts for the 221 participants active in the Plan as of April 30, 2021. We then combined and analyzed the survey responses from the 120 individuals who returned the survey.
- From the population of 98 claimant petitions filed with a Division of Administrative Hearings (DOAH) administrative law judge (ALJ) during the period July 2019 through April 2021, examined NICA records for 25 selected claimant petitions to determine whether NICA adhered to filing time frames established in State law.
- From the population of 29 NICA participant compensation awards executed during the period July 2019 through April 2021, examined NICA records for 10 selected awards to determine whether claims eligibility determinations were made in accordance with State law, participant claims were appropriate and timely paid, and whether the present value of the total costs of the participant claims were timely estimated.
- Interviewed NICA management and inspected NICA records for the present value of total claims costs for the quarters ended June 2020, September 2020, December 2020, and March 2021 to determine whether NICA updated the present value of total claims costs on a quarterly basis in accordance with State law.
- From the population of 19,628 participant reimbursement claims paid during the period July 2019 through April 2021 and totaling $34,085,871, examined NICA records for 25 selected participant reimbursement claims totaling $150,251 to determine whether NICA ensured that participants were awarded compensation and that, prior to authorization, reimbursement requests were appropriately supported and allowable under State law. Additionally, we:
    - Examined NICA records for the 25 selected participant reimbursement claims to determine whether any potential conflicts of interest between NICA personnel or the NICA Board and the participant or contracted service and equipment providers requesting reimbursement were properly disclosed.
    - Reviewed NICA correspondence logs for the 25 participants associated with the selected reimbursement claims to determine whether NICA provided accurate information to the participants and did not indicate that statutorily allowable goods or services submitted for reimbursement would be denied.
- To determine whether NICA established adequate controls to ensure the timely collection and remittance of assessment fees to the Plan, examined NICA records for:
    - 40 participating physicians and midwives, selected from the population of 1,536 physicians and midwives participating in NICA as of April 23, 2021, and with assessments totaling $7,680,000.
    - 40 non-participating physicians, selected from the population of 80,876 medical doctors and 9,746 osteopathic physicians with active licenses as of May 13, 2021, and May 27, 2021, respectively.
    - 40 hospitals, selected from the population of 308 hospitals with active licenses as of May 13, 2021, including 19 hospitals with reported live births totaling 31,779 for the 2019 calendar year, selected from the population of 118 hospitals with reported live births totaling 214,909 for the 2019 calendar year.

- Analyzed NICA billing and payment data for the 86,963 non-participating physicians with assessment amounts due by January 1, 2020, and 118 hospitals with assessment amounts due by January 1, 2021, to determine whether NICA charged periodic interest fees to delinquent accounts.
- Interviewed NICA management, inspected NICA participant records, and reviewed DOAH case summaries for the 116 NICA cases with orders issued during the period July 2019 through April 2021 to determine whether participants had filed benefit disputes with DOAH and whether NICA had established processes to track denied claims for reimbursement.
- From the population of 1,713 general and administrative expenses, totaling $6,165,766 and incurred during the period July 2019 through April 2021, examined NICA records for 97 selected expenses, totaling $705,150, to determine whether NICA general and administrative expenses were adequately supported, clearly necessary to the performance of NICA's statutory duties, and served an apparent public purpose.
- Interviewed NICA management and examined NICA records related to NICA's text and instant message and iMessage retention capabilities to determine whether NICA had established adequate controls to retain text and instant messages and iMessages in accordance with State law.
- Obtained an understanding of NICA network domain, VPN, and Claims Accounting and Reserves Electronic System information technology (IT) controls, assessed the risks related to those controls, evaluated whether selected general IT controls were in place, and tested the effectiveness of the selected controls.
- Interviewed NICA management and reviewed NICA Board meeting records to determine whether Board meetings were publicly held, properly noticed, and promptly recorded in the public record during the period July 2019 through April 2021. Additionally, we examined NICA records to whether Board members did not have or properly disclosed any conflicts of interest with entities, Plan participants, or goods or service equipment providers discussed in Board meetings.
- To gain an understanding of ongoing NICA litigation, interviewed NICA management and NICA's general counsel, reviewed Sections 409.910 and 766.31, Florida Statutes, NICA records, and the legal orders and pleadings for case No. 19-cv-61053 in the Southern District of Florida, and case No. 20-13448 in the Eleventh Circuit Court of Appeals.
- Communicated on an interim basis with applicable officials to ensure the timely resolution of issues involving controls and noncompliance.
- Performed various other auditing procedures, including analytical procedures, as necessary, to accomplish the objectives of the audit.
- Prepared and submitted for management response the findings and recommendations that are included in this report and which describe the matters requiring corrective actions. Management's response is included in this report under the heading ***MANAGEMENT'S RESPONSE***.

AUTHORITY

Chapter 2021-134, Laws of Florida, requires the Auditor General to conduct an operational audit of the Florida Birth-Related Neurological Injury Compensation Association and issue a written report by August 15, 2021. Pursuant to the provisions of Section 11.45, Florida Statutes, and Chapter 2021-134, Laws of Florida, I have directed that this report be prepared to present the results of our operational audit.

Sherrill F. Norman, CPA
Auditor General

EXHIBIT A

2021 NICA-RELATED LEGISLATION

Effective June 21, 2021, Chapter 2021-134, Laws of Florida, made several changes to the NICA Plan. Specifically, the law:

	Requires NICA to administer the Plan in a manner that promotes and protects the health and best interests of birth-injured children.
	Increases the maximum amount that may be awarded to parents or legal guardians of an infant who has sustained a birth-related neurological injury from $100,000 to $250,000 for pending petitions or claims filed on or after January 1, 2021, with the amount increased by 3 percent annually. This provision also applies retroactively to claims filed before January 1, 2021.
	Increases the death benefit for an infant who sustained a neurological injury from $10,000 to $50,000. This payment is retroactive.
	Increases the number of directors on NICA's Board of Directors from five to seven by adding a parent or legal guardian of a Plan participant and a representative of an advocacy organization for children with disabilities.
	Increases transparency requirements for the NICA Board of Directors.
	Provides an annual benefit of $10,000 for the immediate family members living with the child for mental health services.
	For the life of the child, provides parents or legal guardians with a reliable method of transportation for the care of the child or reimburses the cost of upgrading an existing vehicle to accommodate the child's needs when it becomes medically necessary for wheelchair transportation.
	Increases housing assistance from $30,000 to $100,000 for the lifetime of the child, including home construction and modification expenses.
	Creates code of ethics for specified personnel and members of the Board of Directors.

EXHIBIT B

PARTICIPANT SURVEY QUESTIONS

NICA Benefit Handbook
1. Did you receive the NICA Benefit Handbook and related materials and information to help you understand your rights and what services and equipment were authorized under the Plan?
2. Did you feel that the NICA Benefit Handbook and related materials and information adequately explained your rights and what services and equipment were authorized under the Plan?
3. If you did not receive the NICA Handbook and related materials or information or felt they were inadequate, please briefly describe the deficiencies and provide suggestions for improvement.
NICA Participant Service
4. If you had questions regarding your benefits under the Plan, did you feel that NICA timely and appropriately responded to your questions?
5. If you answered 'Yes' or 'No' to question 4, please rate your level of satisfaction with NICA's response to your questions (a through e with e being very satisfied).
6. If you were less than satisfied, please provide details describing the reason(s) for your lack of satisfaction.
Claims Reimbursement
7. If you requested reimbursement for expenses from medical providers and pharmacies, did NICA approve your request?
8. If you answered 'No' or 'Sometimes' to question 7, please provide a brief description of the reason(s) NICA provided for denying your request.
Benefit Dispute
9. If you requested, by letter, that a benefit be reviewed by the Executive Director as an exception, was the Executive Director's decision adequately explained and satisfactory?
10. If you answered 'No' to question 9, please describe what was lacking from the explanation and the reason(s) for your lack of satisfaction.
11. If you answered 'No' or 'Sometimes' to questions 7 or 9, did you file a dispute with the Division of Administrative Hearings?

August 12, 2021

Ms. Sherrill F. Norman, CPA
Auditor General
Claude Denson Pepper Building, Suite G74
111West Madison Street
Tallahassee, FL 32399-1450

Dear Ms. Norman:

Thank you for sharing a copy of the Auditor General's Office Operational Audit Report for the Florida Birth-Related Neurological Injury Compensation Association (NICA) with me and allowing an opportunity to respond to the report. Please accept this as the formal response for NICA.

I appreciate the courtesy extended by the staff of the Auditor General's Office as well as the auditors who performed the testing during the course of the audit. The testing appeared to be accomplished quickly and diligently and we appreciate the efforts made to perform the audit with minimum intrusion or disruption of the normal functional processes within our offices.

There were seven unique findings presented to which NICA would like to respond:

Plan Administration

Finding 1: NICA had not established a mechanism to effectively and consistently document, account for, and track benefit denials or disputes.

Response: NICA is in the process of revising the CARES system to automatically track benefit denials and disputes and revising procedures to consistently and effectively monitor this process. While the current process warrants improvement to be more efficient and easier to monitor, NICA has not used attorneys for denials of benefits nor litigated a benefit issue since 2013. Improving the tracking and reporting of denials will help us better document those cases in which the benefit request is not initially approved for lack of documentation but is ultimately approved and paid. We are also looking at defining what a claim or request for benefits is, what an inquiry is, what a denial is and what a request for additional information should look like so that the system correctly identifies and monitors each of these situations. The work on the system now anticipates including procedures to communicate and track all of this automatically using function keys and codes to capture the correct information and templates generated by the system to assure consistent communication to the families

FLORIDA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION
KENNEY SHIPLEY • EXECUTIVE DIRECTOR
P.O. BOX 14567 • TALLAHASSEE, FLORIDA 32317-4567 • (850) 488-8191
FACSIMILE (850) 922-5369 • WWW.NICA.COM

of the appropriate actions taken by NICA and whether and what the dispute resolution method is available for that action.

Finding 2: Analysis of Plan participant survey responses indicated that the NICA *Benefit Handbook* could be enhanced to better inform participants of their benefits and rights and that NICA could take steps to ensure that benefit request decisions are documented and adequately explained to participants.

Response: Although the percentage of "satisfied" responses consistently exceeded the "dissatisfied" responses by a significant amount, NICA agrees that the NICA Benefit Handbook should be enhanced to better inform participants of their benefits and rights. Modifications to the Benefit Handbook to address the issues raised and others are in process and should be available in DRAFT on the NICA website by the time the final report is published. In addition, on the NICA website NICA is asking for input on this DRAFT Benefit Handbook so that we can understand additional enhancements that families would like to see. NICA has also set up a "Blast" email account to communicate with and update families with new information. NICA is currently using that to notify families of new benefits and procedures and to share answers to questions that have been raised by one or more families with all families to keep them better informed.

Finding 3: NICA records did not always include the rationale for denying or limiting participant claim reimbursements.

Response: NICA is in the process of establishing reason codes to utilize with denials or partial denials (limits on reimbursement) and procedures to utilize system generated template communications that will be issued and explain the limitation or denial in an understandable format. Once developed they will be included in the Benefit Handbook to help Families understand what to do when they receive one.

NICA Assessments

Finding 4: NICA did not timely or consistently use all available remedies to collect delinquent assessment amounts from non-participating physicians. As of June 16, 2021, active non-participating physicians owed NICA $14,367,193 for assessment amounts due for the 2016 through 2021 assessment years.

Response: In finding 4, the audit report states that the total outstanding non-participating physician assessments is $14.4 million dollars for assessment years 2016-2021. NICA disagrees with this stated total. Based on the same data utilized by the auditors in preparing the audit report, NICA estimates the total for non-exempt, outstanding assessments to be closer to $8.4 million rather than $14.4 million. NICA believes the discrepancy between the two figures is due to the fact that the $14.4 million total includes those physicians who are not required to pay the assessment as set forth in section 766.314(1)(b)4., Florida Statutes. Section 766.314(1)(b)4., Florida Statutes,

provides that the NICA assessment is "not applicable" to the physicians falling within the categories listed in that section, but, until NICA receives documentation demonstrating that a physician is exempt from paying the assessment, NICA sends an invoice for the annual assessment amount. NICA then flags those non-participating physicians who appear to be eligible for an exemption based on the license status on the Department of Health website. Additionally, past due payments are received on a rolling basis. Based on experience, NICA believes that the majority of the outstanding $8.4 million will be received within the next 12 months.

In finding 4, the audit report also recommends that: "NICA management timely and consistently use all available remedies to collect delinquent assessment amounts." As recognized in the audit report, however, the only mechanism available to NICA to enforce collection of the non-participating physician assessments is the filing of a lawsuit in county court as set forth in section 766.314, Florida Statutes. NICA routinely avails itself of this remedy but determined that it was more beneficial and cost effective to file suits in batches covering multiple assessment years to avoid incurring costs that NICA would likely not recover if suit is filed too soon and does not allow sufficient time for the physicians to document entitlement to the exemption set forth in section 766.314(1)(b)4., Florida Statutes. If NICA files suit against a physician who later provides documentation that the physician is exempt from paying the assessment, NICA must dismiss the suit and cannot recover any of the associated fees, court costs or attorney's fees incurred in pursing that suit. As mentioned above, based on NICA's experience, the exempt physicians may take two or three years before they provide the requisite documentation. Filing in batches every few years, not only defrays costs but is more likely to result in collection of past due amounts since the exempt physicians have had ample time to provide documentation. There is no mechanism for NICA to require that physician timely provide documentation demonstrating that they are exempt. NICA includes this in the invoices, but there is no means afforded to NICA in statute to enforce this requirement.

The process of filing suit to enforce payment of the NICA assessments requires substantial time and cost to complete. While NICA is entitled to attorney's fees and costs once a judgment is entered and the physician satisfies that judgment, NICA must pay upfront the costs associated with proper service of demand letters, filing fees, costs associated with serving the summons and attorneys' fees. The audit report recommends that NICA timely avail itself of the remedy available to it but does not indicate what the auditors view as "timely." NICA submits, it is simply not practicable or reasonable to file suit seeking payment of past due assessments that are not at least three to four years past due. To do so would require a significant dedication of staff resources and result in NICA unnecessarily incurring costs that it will not recover in many instances. During this timeframe, many of the physicians who are entitled to the exemption will provide the necessary documentation, thus obviating the need to file suit against them in year 4 and avoid incurring unnecessary costs to NICA.

On a going forward basis, NICA will ensure that it files suit seeking past due payments in a more consistent manner to timely collect the past due amount. For instance, currently, NICA is in the process of sending demand letters for delinquent physician assessments that are 5 years overdue. NICA will then proceed with filing suit in county court against those physicians that do not respond to the demand letters. NICA will work toward filing suit every two years to collect the past due assessments that are over 4 years past due.

Selected Administrative Activities

Finding 5: NICA expenses associated with holiday luncheons for NICA personnel did not appear to be clearly necessary to the performance of NICA's statutory duties. Additionally, meals provided for NICA personnel and Board members were not limited to the amounts provided by State law.

Response: – Finding 5 relates to certain limited expenses questioned by the auditors. Each category of expenses will be addressed separately below:

- General Administrative Expenses: The audit report takes issue with NICA hosting two holiday luncheons for its NICA personnel in December 2019 and December 2020 with expenses totaling $363 and $421, respectively. As noted in the audit report, it is NICA's view that these luncheons benefit the morale of NICA's employees and were necessary to the performance of NICA's administration of the Plan. On a daily basis, NICA's nurse case managers work with families who care for their catastrophically injured children. While the nurse case managers find their work very important and rewarding, it can be emotionally taxing at times. NICA management viewed the provision of a small holiday lunch for its personnel as important for lifting morale. With that said, on a going forward basis, NICA will not utilize its administrative funds to provide for events of this nature. Additionally, with respect to the audit finding that NICA's chart of accounts did not readily allow coding for these types of expenses, NICA will review its chart of accounts and add additional fields, where necessary, to promote the appropriate recording of all administrative expenses.

- Meals provided at the NICA Board and Medical Advisory Committee meetings: The audit report addresses 2 NICA Board meetings and one Medical Advisory Committee meeting where NICA provided food in a buffet style manner for the Board members and attendees. Several people attend the Board and committee meetings including Board and Committee members, NICA staff, and various other parties such as investment consultants, actuaries and auditors who may be asked to present materials at these meetings. NICA contracted in advance with the hotel to have a buffet set up in the meeting room to allow the meetings to continue without breaking for meals. NICA staff, Board members, Committee members and other presenters were not reimbursed for meals when food was provided as part of the meeting. NICA viewed the provision of these meals as important to the performance of NICA's administration of the Plan.

When the meetings continue without breaking, the overall associated travel costs are potentially lessened because the members and staff can leave earlier in the day to travel home thereby reducing the costs of hotel and additional meals. On a going forward basis, however, NICA will comply with section 112.061, Florida Statutes regarding meals of this nature during NICA Board meetings or Medical Advisory Committee meetings.

- Staff Travel Expenses: The audit report questions certain limited travel reimbursements to NICA staff totaling $$1,046 as exceeding that authorized by section 112.061, Florida Statutes. The audit report cites section 112.061, Florida Statutes, as applicable to NICA. NICA, however, does not fit squarely within the definition of a "agency" or "public agency" as set forth in section 112.061(2)(a), Florida Statutes. Section 766.315(3), Florida Statutes, subjects to travel reimbursement pursuant to 112.061, but there is no specific application of that statute to NICA staff. As such, NICA adopted the following policy for travel expense reimbursement:

> Without a receipt, meals will be paid at the rate of $6 for breakfast, $11 for lunch and $19 for dinner, or the highest current amount allowable by the State of Florida regulations. With receipts, actual reasonable hotel and meal expenses may be reimbursed or the State of Florida approved per diem may be paid. To be eligible for breakfast travel must begin before 7:00 a.m., lunch travel must begin before 12:00 noon and dinner travel must end after 8:00 p.m.

As demonstrated by the above-quoted NICA policy, NICA is generally in compliance with the travel reimbursement requirements set forth in section 112.061. The only issue the auditors noted was that portion of NICA's policy which permits NICA personnel to be reimbursed for or charge to a NICA issued credit card, the actual meal expense rather than limiting the costs to the statutory state rate noted above Although NICA believes it was correct in allowing the questioned reimbursement pursuant to its policies, on a going forward basis NICA will follow the requirements of section 112.061, Florida Statutes. As recommended, NICA is in the process of updating its Procedures Manual to require that reimbursable meal expenses and meals charged to a NICA-issued credit card not exceed statutorily authorized reimbursement rates.

Finding 6: NICA controls did not promote the retention of text and instant messages in accordance with State public records laws.

Response: Use of NICA owned cellular phones for staff members, other than the Executive Director and Deputy Director, was implemented as part of the response to allow employees to work remotely during the COVID 19 pandemic.

NICA is researching methods to ensure that all text and instant messages are captured and retained in accordance with State law.

NICA is working with the provider to disable text messaging features from these devices and to find alternative means to allow remote personnel to have voice communication without text messaging.

Information Technology Controls

Finding 7: Certain security controls related to user authentication for the network domain, NICA virtual private network (VPN), and Claims Accounting and Reserves Electronic System need improvement to ensure the confidentiality, integrity, and availability of NICA data and information technology resources.

Response: NICA takes the security and protection of the NICA entrusted data with the utmost care. NICA currently implements multilayered security controls to ensure the confidentiality, integrity and availability of NICA data and information technology resources. Additionally, both the network and CARES applications have separate security controls which include access, roles/permissions, and unique user credentials. HIPPA requires NICA to comply with physical, technical, and administrative safeguards to guarantee privacy, confidentiality, data integrity, and security for all information in motion and at rest. The physical controls span from facility access, device timeouts, and bitlocker, as well as, back-ups for each device and environment. Technical standards have been addressed in the previous comment. Administratively, each user signs non-competes, NARFS, and Confidentiality agreements. Training and policy manuals are provided all users. To further enhance security, many controls are managed at the policy level thereby reducing NICA exposure to risk. Finally, each device and the environment at large is further protected by virus and intrusion detection firewalls. NICA continuously monitors its environment and spends countless hours ensuring all software is current including releases (once evaluated for compatibility and risk) and patch management. NICA management will implement recommendations from the AG to further increase security controls related to user authentication for the network domain, NICA virtual private network and internal applications.

I believe NICA's actual and proposed corrective actions for each finding will satisfy the issues raised in the identified findings. If you have any questions or further recommendations, please let me know.

Sincerely,

Kenney Shipley
Executive Director

SB 1786 UPDATE: MEDICAID NICA REPORT

Brian Meyer, Assistant Deputy Secretary for Medicaid Operations

Senate Banking and Insurance Committee

December 1, 2021

MEDICAID NICA REPORT

Legislation Overview

- The bill directed the Agency to review its Medicaid Third-Party Liability (TPL) functions and rights relative to NICA and develop a report that:
  - Reviews the extent and value of the liabilities owed by NICA as a third-party benefit provider.
  - Provides recommendations regarding the development of policies and procedures to ensure robust implementation of Agency functions and rights relative to the primacy of the plan's third-party benefits and potential recoveries.
- Report submitted to the President of the Senate, Speaker of the House, and Chief Financial Officer on November 1, 2021.

MEDICAID NICA REPORT

Medicaid Third-Party Liability Functions

- Medicaid is the “payer of last resort.” Medicaid pays for health care services only after other responsible third parties have met their burden of costs.
- Exceptions to this requirement are outlined in 42 U.S.C. § 1396a(a)(25)(A)-(B)
- Section 409.910, F.S., the “Medicaid Third-Party Liability Act,” governs TPL within Florida:
  - “It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medicaid recipients.”

MEDICAID NICA REPORT

Report Findings

- Medicaid is the “payer of last resort,” and pays for health care services only after other responsible third parties have met their burden of costs.
- Medicaid could be considered payer of last resort with respect to medical expenses for recipients who are also eligible for and enrolled in NICA.
- While Florida Medicaid engages in various recovery efforts, there are four potential areas of TPL focus as it relates to NICA:
  - Cost Avoidance
  - Carrier Billing
  - Disallowance
  - Casualty Cases

MEDICAID NICA REPORT

Report Findings

- The Agency reviewed expenditures of all Medicaid recipients from NICA's inception on January 1, 1989, to August 30, 2021.
- The Agency pulled information representing all services for each recipient for which Medicaid reimbursement was made, excluding preventative well-child and dental services.

Total Expenditures and Total Non-Routine Expenditures (1989-2021)

Total Expenditures FFS: $93,293,283.52
Total Expenditures MCO: $50,550,487.72
Total Overall Expenditures: $143,843,771.24

Total Non-Routine* Expenditures FFS: $93,171,652.60
Total Non-Routine* Expenditures MCO: $50,456,435.63
Total Overall Non-Routine Expenditures: $143,628,088.23
**Non-Routine Expenditures exclude Dental, Visual, and Health Check Up expenditures*

MEDICAID NICA REPORT

Report Findings

Top 10 FFS Service Types by Total Expenditures (1989-2021)

Service Type	Total by Service
HOSPITAL INPATIENT SERV	$22,855,626.48
PRIVATE DUTY NURSING SERVICES	$22,671,983.86
UNKNOWN	$13,370,517.49
HOME HEALTH SERVICES	$6,279,081.91
PERSONAL CARE SERVICES	$4,827,328.64
HOSPITAL OUTPATIENT SERVICES	$4,228,886.92
HCB DEVELOPMENTAL SERVI	$3,442,303.88
PHYSICIAN SERVICES	$2,742,592.17
SMMC CMSN DOH MMA	$1,634,418.85
OCCUPATIONAL THERAPY SERVICES	$1,561,214.53

Top 10 MCO Service Types by Total Expenditures (1989-2021)

Service Type	Total by Service
PRIVATE DUTY NURSING SERVICES	$21,180,051.40
HOSPITAL INPATIENT SERV	$11,005,349.31
HOME HEALTH SERVICES	$5,435,789.21
PRESCRIBED MEDICINE	$3,009,319.25
PHYSICIAN SERVICES	$2,798,408.53
HOSPITAL OUTPATIENT SERVICES	$1,999,863.66
HCB AGING	$1,388,804.95
PHYSICAL THERAPY SERVICES	$960,544.15
PATIENT TRANSPORTATION	$638,969.50
OCCUPATIONAL THERAPY SERVICES	$492,329.02

MEDICAID NICA REPORT

Report Recommendations

The Agency has provided multiple options for consideration by the Legislature:

- ***Retrospective Medicaid Recovery***
  - Agency could attempt to recoup from NICA funds previously paid by Medicaid.
  - Agency will need Legislative guidance as to how to determine the amount to be recovered from NICA.
- ***Cost Avoidance***
  - Identify NICA members who also are covered by Medicaid.
  - Create and assign a carrier code for NICA in FMMIS to treat NICA as any other third-party medical insurer or carrier that providers must bill first before seeking payment from Medicaid.
- ***Prospective Medicaid Recovery***
  - The Agency could participate in administrative proceedings to determine NICA eligibility and assert its rights as third party payor for future expenses and the right to recover expenses already paid.

QUESTIONS?

RON DESANTIS
GOVERNOR

SIMONE MARSTILLER
SECRETARY

November 1, 2021

Wilton Simpson, President
Florida Senate
409 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Chris Sprowls, Speaker
Florida House of Representatives
420 The Capitol
402 South Monroe Street
Tallahassee, FL 32399-1300

Jimmy Patronis, Chief Financial Officer
Florida Department of Financial Services
Plaza Level 11, The Capitol
Tallahassee, FL 32399-0301

Pursuant to Chapter 2021-134, Laws of Florida, please see the attached report on Florida's Birth-Related Neurological Injury Compensation Association (NICA) and its relationship with Florida Medicaid.

Please do not hesitate to contact our team if you have any questions.

Sincerely,

Simone Marstiller
Secretary

2727 Mahan Drive • Mail Stop #
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Twitter.com/AHCA_FL

The Neurological Injury Compensation Association and Florida Medicaid Third-Party Liability

Report to the Florida Legislature
November 2021

Table of Contents

Executive Summary

During the 2021 Florida legislative session, Senate Bill 1786 expanded funding for the Florida Birth-Related Neurological Injury Compensation Association (NICA) while also requiring that the Agency for Health Care Administration (Agency) review NICA and its relationship with Florida Medicaid, specifically Medicaid's Third-Party Liability (TPL) functions which require that Medicaid be a "payer of last resort." The Agency report is required to provide recommendations regarding the development of policies and procedures to ensure "robust implementation of Agency functions and rights relative to the primacy of the plan's third-party benefits."

The Neurological Injury Compensation Association (NICA) was established in Florida in January 1989 to help reduce OB/GYN malpractice premiums and at the same time "provide a dignified existence and financial cushion for families crushed by the delivery of an infant with devastating brain damage" by funding their medical expenses. Hospitals and practitioners are assessed varying amounts by NICA each year to fund its mission which is to "pay for all medically necessary and reasonable expenses over the child's lifetime."

Florida Medicaid was established in 1970 as the primary Federal program for providing care to certain low-income individuals and families. The program is a state-federal partnership with federal law establishing the overarching rules and guidelines, the state designing and running the program, and with costs shared between the two based on a ratio determined by the state's average personal income.

One of the key principles when Medicaid was established was the concept of acting as a "payer of last resort." In other words, Medicaid is meant to pay for health care services only after other responsible third parties have met their burden of costs. Federal and state law have firmly established the concept of Medicaid as a payer of last resort. This means third-party payers are liable for a beneficiary's health care up to their coverage limits before Medicaid will contribute to the health care costs. See 42 U.S.C. § 1396a(a)(25)(A)-(B) Exceptions to this requirement are clearly outlined in Federal Law.

Cost Avoidance – Medicaid providers either identify NICA recipients during eligibility checks and bill NICA directly, or Medicaid denies claims for which NICA is the primary payor and informs the provider of the reason for the denial.

Prospective Medicaid Lien/Claim Recovery – The Agency or SMMC plan would participate in the DOAH hearing to determine NICA eligibility and assert its rights as third party payor for future expenses and the right to recovery of expenses already paid. This option would require modification and clarification in the Florida Statutes by the Florida legislature.

Retrospective Medicaid Lien/Claim Recovery - For NICA DOAH proceedings that have already concluded, in which a recipient's claim was determined to be NICA compensable, the Agency may still have a claim against NICA. If decided by the Legislature, the Agency could attempt to recoup, from NICA, funds previously paid by Medicaid. The Agency will need Legislative guidance as to how to determine the amount to be recovered from NICA.

In summary, Medicaid could be considered payer of last resort with respect to medical expenses for recipients who are also eligible for and enrolled in NICA. There are three possible approaches to ensuring the primacy of NICA's third-party liability, but each will require legislative changes.

The Neurological Injury Compensation Association (NICA)

The Neurological Injury Compensation Association's (NICA) had its origins in the malpractice liability crisis of the early 1980s. During that decade's first six years, Florida OB/GYNs premiums for malpractice liability insurance rose nearly 400 percent. During the 1988 legislative session, Florida lawmakers pursued a two-prong course of action that would greatly decrease OB/GYN malpractice premiums and at the same time "provide a dignified existence and financial cushion for families crushed by the delivery of an infant with devastating brain damage." NICA took effect on January 1, 1989, with the legislature making a one-time $20 million appropriation for its commencement. No further state or federal funds have been used to support this program. Rather, hospitals and practitioners make payments of varying amounts to NICA each year. As of early 2021, 1,238 parents or guardians filed petitions for their infants' acceptance into the program; of these applicants, Florida's NICA program accepted 440 children as beneficiaries.

NICA's website states that "NICA pays for all medically necessary and reasonable expenses over the child's lifetime. Examples of covered expenses may include medical care, co-pays, equipment, therapy, nursing care, medications, handicap modifications, transportation, and supplies that are medically necessary but not covered by another source, such as insurance. NICA aims to treat every family in the program fairly and individually, providing each child with the personalized benefits they are entitled to, based on their specific medical needs. What is medically necessary for one child may not be the same for another, so a one-size-fits-all approach does not work for NICA."

Section 766.31, Florida Statutes, states that each award shall provide for compensation relating to the birth injury, including "(a) Actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel."

Florida Medicaid – Payer of Last Resort

Federal Laws

Medicaid, established by Title XIX of the Social Security Act of 1965, is the primary Federal program for providing care to certain low-income individuals and families who fit in an eligibility group. The program is voluntary, though presently all States and territories maintain Medicaid programs. These programs are administered by states, but financed cooperatively, with the federal government and states sharing the costs incurred for this medical care. A "State plan," the foundation on which State Medicaid programs are established, is a Federally approved document which designates a single agency to administer the program and provides a description and scope of the State's Medicaid program. The State plan ensures that the State's Medicaid program will conform with all federal regulations and requirements.

One issue that all State Medicaid programs face is "third party liability" (TPL). TPL effectuates the "payer of last resort" policy, meaning Medicaid will only pay a beneficiary's health care costs when there are "no other liable third-party payers for the same items and services." Third parties are a broadly defined set of resources, including health insurers, government programs, and liable people or entities, which are responsible for paying for a beneficiary's health care. In instances a third party is responsible for the medical expenses of a beneficiary, the Federal government provides State Medicaid programs with a mandate both establishing the program as, and in exercising its right to be, a "payer of last resort." This means third-party payers are liable for a beneficiary's health care up to their coverage limits before Medicaid will contribute to the health care costs. In other words, the State Medicaid program will only pay for health care services after the third-party payer has reimbursed for services within its responsibility. The exceptions to this payer of last resort right are clearly specified in federal statue. These exceptions mean that State Medicaid programs will pay for beneficiary health care prior to any of the following incurring an expense:

- Crime Victims Compensation Fund
- Parts B and C of the Individuals with Disabilities Education Act (IDEA)
- Ryan White Program
- Indian Health Services
- Women, Infants, and Children Program
- Veteran's benefits, for emergency treatment provided to certain veterans in a non-VA facility
- Veteran's benefits for state nursing home per diem payment
- State health agencies
- State vocational rehabilitation agencies,
- Title IV-E prevention and family services (Section 8082(b)(1) of H.R. 6 was amended by section 471(e)(10) of the Act effective October 3, 2018).

In 2005, to confirm that State Medicaid programs were the "payer of last resort," the Federal government required states to demonstrate they maintain laws which establish this policy beyond the shadow of a doubt. States possess an arsenal of federal laws on which to base their stance on TPL. First, to assist in identifying third party payers, federal statutes require "that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties." To assist in this process, the beneficiary is required "to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." Second, the Code of Federal Regulations states that if a State Medicaid program "has established the probable existence of third-party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment." Florida, through statutes and administrative rules, demonstrates that it observes the 2005 requirement.

In addition, Federal authority establishes provisions that require states to seek reimbursement from liable third parties. Specifically, 42 U.S.C. § 1396a(a)(25)(B) provides in pertinent part: "that in any case in which such a legal liability is found to exist after medical assistance has been made available on behalf of the individual the State will seek reimbursement for such assistance to the extent of such legal liability." To assist with obtaining this reimbursement, Federal law requires that "States must condition Medicaid eligibility on assignment to the state of any Medicaid recipient's rights to payment for medical

care from any third party." By assignment, a Medicaid applicant or recipient automatically gives his/her right to financial recovery from liable third parties to the Agency, to the extent Medicaid has paid for medical services. This allows the recovery of the costs of medical services paid by the Medicaid program. Any applicant or recipient who knowingly withholds information regarding any sources of payment for medical services violates state law.

When Florida chose to participate in Medicaid in 1970, the state developed a "State plan" which defined the program's nature and scope. Through this state plan, Florida agreed to conform to federal Medicaid law, including payer of last resort and collection of reimbursement or TPL. The state similarly enacted laws which established Florida's Medicaid program as the payer of last resort and required the Agency to pursue TPL. Additionally, compliance with federal law implies that Florida has the obligation to collect reimbursement from third party payers.

State Laws

Section 409.910, F.S., also known as the "Medicaid Third-Party Liability Act," governs TPL within Florida. In the first sentence of the statute, the Legislature leaves no doubt regarding its objective: "It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medicaid recipients." Consistent with federal law's requirement that State collect third-party reimbursement, Florida law provides that in "applying for or accepting medical assistance [Medicaid], an applicant, recipient, or legal representative automatically assigns to the agency any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law." Section 409.910, F.S., also requires that "if benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full, from and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid."

Florida Administrative Code (F.A.C.) Rule 59G-1.052 elaborates upon TPL requirements within the state. Built upon the foundation of the Code of Federal Regulations (CFR), section 433, Subpart D, Rule 59G-1.052 confirms that "all other available third-party resources must meet their legal obligation to pay claims before the Florida Medicaid program pays for a recipient's health care services." Through a combination of Federal and state laws, the following programs are exempt from abiding by the payer of last resort requirement:

- Federal funds for the Individuals with Disabilities Education Act, Part B or C.
- Indian Health Services, according to 42 CFR 136.61.
- Programs funded through state and county funds, including:
    - Acquired Immune Deficiency Syndrome (AIDS) drug assistance programs.
    - County health departments.
    - Department of Health indigent drug programs.
    - Substance abuse, mental health, and developmental disabilities programs operated by the Department of Children and Families and the Agency for Persons with Disabilities.
    - Victim's compensation funds.
- Vocational rehabilitation programs.

For all other third-party resources, “Florida Medicaid is the payer of last resort. Providers must exhaust all TPL sources of payment, such as Medicare, TRICARE, private health insurance, AARP plans, or automobile coverage prior to submitting or resubmitting a claim for reimbursement to Florida Medicaid.” In addition, the rule enables the Agency, to contract with “a TPL vendor to identify, manage, and recover funds and overpayments paid on behalf of recipients when a third-party is, or was, responsible. The TPL vendor also administers Florida Medicaid’s third-party liability recovery programs for casualty, estate, trust, and annuities on behalf of deceased Medicaid recipients.”

Medicaid Third-Party Liability Functions

The Agency Division of Medicaid’s Third-Party Liability (TPL) unit is responsible for identifying and recovering funds for fee-for-service claims paid by Medicaid when a third-party is liable for a recipient’s medical expenses, thereby ensuring Medicaid is the payer of last resort. Some examples of third parties include casualty settlements, recipient estates and/or trusts, Medicare, and commercial health insurance carriers. TPL recovery services are performed by a state procured outside vendor, Health Management Systems, Inc (HMS). The Agency is contracted with HMS through August 31, 2025.

Although Florida Medicaid engages in various recovery efforts, focuses on four areas of TPL activity:

Cost Avoidance – As previously stated, health insurance carriers are required to exchange or share data with state Medicaid agencies for the coordination of benefits or COB. Through these data matches, new and/or updated health insurance information is obtained. Insurance information is also obtained at the time of enrollment into Medicaid. When Medicaid staff or Medicaid providers are informed that a recipient has acquired new insurance, they can contact the TPL vendor. The TPL vendor will verify that the insurance information is correct and current. That information is then added to the Florida Medicaid Management Information System (FMMIS) to cost-avoid future claims that are submitted by Medicaid providers.

When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid. The Agency utilizes automated rule processes maintained in FMMIS to determine whether a claim shall be paid or denied based upon other third-party information contained in the Medicaid recipient's file. Medicaid tracks cost avoidance to illustrate total Medicaid dollars saved or avoided when providers bill the appropriate third-party.

Carrier Billing - Once commercial health insurance is identified for Medicaid recipients and added to their record in FMMIS, the TPL vendor bills the insurance carriers for previously paid Medicaid claims that are covered by the primary health insurance. The primary health insurance then reimburses Medicaid for the amount it paid. This is known as carrier billing.

Under the Florida SMMC, Medicaid Managed Care Plan(s) are required to identify and seek recovery up to the Managed Care Plan’s full legal ability from any third party, as defined by 409.901(27), F.S., to pay for services rendered to enrollees.

The Managed Care Plan is required to assume full responsibility for all third-party recovery actions initiated within one (1) year of identification. All recovery actions not initiated by the Managed Care Plan within one (1) year of identification may be pursued by the Agency, at the Agency’s sole discretion.

Disallowance -Instead of the TPL vendor billing the private health insurance company, they provide the Medicaid claim and private health insurance information to the provider which then directly bills the carrier. If the health insurance company issues payment to the provider for the services, the TPL vendor will recover Medicaid's initial payment to the provider. If the health insurance company does not pay, the Medicaid payment is not recovered from the provider.

Casualty Cases – Medicaid imposes a lien against recipients' recoveries from liable third parties for the amount Medicaid paid for medical services related to injuries sustained as the result of an incident (casualty). Examples of casualties are automobile accidents, slip and fall accidents, medical malpractice, etc. Under normal circumstances, Florida Medicaid learns that a casualty has occurred when an attorney, representing the Medicaid recipient, brings a claim against a liable third-party. When an attorney believes their client may have Medicaid, they are required to notify Florida Medicaid. Then Medicaid relies on section 409.910, F.S., to make recoveries for payments on behalf of Medicaid-eligible persons when other parties are liable. Conduent Payment Integrity Solutions (Conduent) is the approved subcontractor of HMS contracted to identify, manage, and recover all Florida Medicaid paid funds when a Medicaid recipient is involved in a tort or a casualty incident.

When Medicaid is noticed, Conduent opens a casualty case file on behalf of Florida Medicaid, calculates the paid claims amount made on behalf of the Medicaid recipient related to the cause of action, follows up with the attorney regularly, and requests payment when third-party benefits are received. The attorney for the recipient then pays Florida Medicaid out of any recovery the recipient makes against liable third parties.

NICA Liability to Florida Medicaid

Section 766.31, Florida Statutes, requires that NICA pay for all medically necessary and reasonable expenses relative to the birth-related neurological injury over the child's lifetime. Specifically, under the statute, NICA must cover "(a)ctual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care, and service, for medically necessary drugs, special equipment, and facilities, and for related travel." This law, together with federal and state laws providing that Medicaid is the payer of last resort, indicate that NICA should be the primary payer for services provided under the plan that Medicaid otherwise would pay for. In other words, NICA should be considered a third-party provider for purposes of Medicaid's TPL function and responsibility.[1]

[1] In 2015, the United States, by way of relators Theodore Arven III and Veronica N. Arven, filed a qui tam whistleblower lawsuit in federal court against the Virginia Birth-Related Neurological Injury Compensation Program and alleged that because the Virginia program would not pay for expenses covered by Medicaid, it violated federal law which holds that Medicaid is the payer of last resort and that the program violated the Federal False Claims Act by requiring claimants in the program to file Medicaid claims for expenses covered by the fund. The United States sought treble damages from the program for its purported False Claims Act violations. The Virginia Birth-Related Neurological Injury Compensation Program and the Virginia Birth-Related Neurological Injury Compensation Fund settled with the United States by agreeing to pay $20,700,000.00 to resolve the False Claims Act suit against them. *See United States ex rel. Arven III v. The Va. Birth-Related Neurological Injury Comp. Program, No. 1:15CV 870 (E.D.Va. July 7, 2015).* In September 2019, the United States, by way of relators Veronica N. Arven and Estate of Theodore Arven III, filed a qui tam whistleblower lawsuit in federal court against the Florida Birth-Related Neurological Injury Compensation Association (NICA) and the Florida Birth-Related Neurological Injury Compensation Plan. The United States alleges that because NICA will not pay for expenses covered by Medicaid, it violates federal law which holds Medicaid is the payer of last resort and that NICA violates the Federal False Claims Act when it requires participants to submit claims to Medicaid before it will consider them and when it does not reimburse Medicaid for expenses covered by the plan if Medicaid pays first. The United States seeks treble damages from NICA because it purportedly violates the False Claims Act. This case is pending. *See United States ex rel. Arven v. Fla. Birth-Related Neurological Injury Comp. Ass'n, No. 19-61053-CIV (S.D. Fla. Sept. 9, 2019)*.

To identify the potential extent and value of the liabilities owed by NICA as a third-party benefit provider, the Agency obtained a list of Florida recipients from NICA and cross-referenced the list with an additional list of NICA recipients received from the United States Department of Health and Human Services Office of Inspector General. Of the 440 accepted into the NICA program, 284 recipients were found to be also enrolled in the Medicaid program. The list represents all Medicaid recipients from NICA's inception on January 1, 1989, to August 30, 2021. The Agency pulled information representing all services for each recipient for which Medicaid reimbursement was made.

For purposes of this report, data is provided as follows:

(1) All services: This data includes reimbursement amounts associated with all services reimbursed for NICA recipients. No services which may be appropriately covered by the Medicaid program if NICA is a third-party payer have been removed from this analysis.
(2) Services excluding preventive well-child and dental services: This data has had reimbursement amounts relating to certain preventive services removed, including well childcare, immunizations, preventative dental and preventative vision, based on the assumption that these services would be provided to any child enrolled in the Medicaid program, regardless of whether that child has suffered a birth-injury.

Figure 1 – Total Expenditures and Total Routine Expenditures (1989-2021)

Total Expenditures FFS: $93,293,283.52
Total Expenditures MCO: $50,550,487.72

Total Non-Routine* Expenditures FFS: $93,171,652.60
Total Non-Routine* Expenditures MCO: $50,456,435.63

**Non-Routine Expenditures exclude Dental, Visual, and Health Check Up expenditures*

Table 1 – Total Expenditures by Calendar Year (1989-2021)

Calendar Year	Total FFS Expenditures	Total MCO Expenditures	Calendar Year	Total FFS Expenditures	Total MCO Expenditures
1989	$150.00	$0.00	**2006**	$5,631,278.77	$0.00
1990	$374.50	$0.00	**2007**	$6,862,332.78	$40.00
1991	$1,061.26	$0.00	**2008**	$6,983,274.08	$2,463.76
1992	$808.17	$0.00	**2009**	$7,426,973.10	$8,373.58
1993	$15,821.15	$0.00	**2010**	$6,758,166.44	$3,375.14
1994	$18,389.03	$0.00	**2011**	$5,901,883.60	$18,320.70
1995	$53,614.55	$0.00	**2012**	$5,408,140.79	$46,186.73
1996	$315,453.46	$0.00	**2013**	$5,339,190.48	$44,170.35
1997	$205,797.16	$0.00	**2014**	$4,068,199.74	$1,663,070.81

1998	$586,690.32	$0.00		**2015**	$2,174,887.13	$5,224,615.31
1999	$889,526.92	$0.00		**2016**	$2,458,881.03	$5,268,753.03
2000	$1,152,185.64	$0.00		**2017**	$2,403,895.39	$6,132,357.96
2001	$2,062,333.36	$0.00		**2018**	$2,318,733.91	$7,839,789.03
2002	$4,914,402.48	$0.00		**2019**	$2,032,895.32	$9,202,873.53
2003	$3,884,157.86	$0.00		**2020**	$2,316,801.69	$9,897,118.12
2004	$4,234,114.88	$0.00		**2021**	$1,655,835.24	$5,104,927.58
2005	$5,100,453.60	$0.00		**TOTALS**	$93,293,283.52	$50,550,487.72

Table 2 – Top 10 FFS Service Types by Total Expenditures (1989-2021)

Service Type	Total by Service
HOSPITAL INPATIENT SERV	$22,855,626.48
PRIVATE DUTY NURSING SERVICES	$22,671,983.86
UNKNOWN	$13,370,517.49
HOME HEALTH SERVICES	$6,279,081.91
PERSONAL CARE SERVICES	$4,827,328.64
HOSPITAL OUTPATIENT SERVICES	$4,228,886.92
HCB DEVELOPMENTAL SERVI	$3,442,303.88
PHYSICIAN SERVICES	$2,742,592.17
SMMC CMSN DOH MMA	$1,634,418.85
OCCUPATIONAL THERAPY SERVICES	$1,561,214.53

Table 3 – Top 10 MCO Service Types by Total Expenditures (1989-2021)

Service Type	Total by Service
PRIVATE DUTY NURSING SERVICES	$21,180,051.40
HOSPITAL INPATIENT SERV	$11,005,349.31
HOME HEALTH SERVICES	$5,435,789.21
PRESCRIBED MEDICINE	$3,009,319.25
PHYSICIAN SERVICES	$2,798,408.53
HOSPITAL OUTPATIENT SERVICES	$1,999,863.66
HCB AGING	$1,388,804.95
PHYSICAL THERAPY SERVICES	$960,544.15
PATIENT TRANSPORTATION	$638,969.50
OCCUPATIONAL THERAPY SERVICES	$492,329.02

Recommended Agency Policies and Procedures

As outlined in the enacting language, the Agency is required to provide recommendations, based on its findings, regarding the development of policies and procedures to ensure robust implementation of agency functions and rights relative to the primacy of the plan's third-party benefits payable under s. 766.31(1)(a)1. and 3., Florida Statutes, and recoveries due the agency under s. 409.910, Florida Statutes.

The Agency reviewed federal and state law and determined that NICA could be considered a third-party payor. If it is determined that NICA is a third party-payor to Florida Medicaid, to ensure robust implementation of agency functions and rights relative to NICA, the Agency will need to be able to identify any existing and future NICA members who also have Medicaid. As such, the Agency makes the following recommendations for the Legislature and Chief Financial Officer to consider:

Retrospective Medicaid Lien/Claim Recovery:

In this report, the Agency has provided the extent and value of the liabilities by NICA if it is considered a liable third-party. For NICA DOAH proceedings that have already concluded, in which a recipient's claim was determined to be NICA compensable, the Agency may still have a claim against NICA. If decided by the Legislature, the Agency could attempt to recoup, from NICA, funds previously paid by Medicaid. The Agency will need Legislative guidance as to how to determine the amount to be recovered from NICA. Below are potential avenues to seek recovery:

1. The Agency may issue demand letters against NICA requesting payment for which the Agency has a legal right.
2. The Agency may have a claim under a federal statute which renders invalid the restrictions on payment for medical care paid by the Agency. The Agency may be able to turn to the federal district courts for relief in individual cases, or for declaratory relief against NICA.

In order to ensure compliance, the Legislature could amend NICA's statute section 766.31 to expressly provide for repayment to the Agency/Medicaid, thus ensuring that the Agency does have a right to repayment, and it gets repaid. Such an amendment may provide a path for the State to require NICA to repay the Agency for previous services rendered which should have been NICA compensable.

Cost Avoidance

In order to perform cost avoidance measures, the Agency will need to identify NICA members. There are two ways to achieve this goal:

1. Execute a Data-Sharing Agreement: The Agency can execute a data sharing agreement with NICA where NICA will provide the Agency with its existing members and then prospectively inform the Agency of any newly added NICA members; and/or;
2. Obtain enrollment information from the DOAH: Currently, per NICA's statute (Section 766.305, F.S.), the parents or guardians of the infant must file a petition with DOAH to determine NICA eligibility. DOAH then serves a copy of the petition to the Agency. Upon receiving notification, the Agency's TPL vendor checks to see if the petitioner is enrolled in Medicaid.

Once the Agency has identified NICA members who also have Medicaid, the Agency will create and assign a specific carrier code for NICA in FMMIS. This carrier code will be treated the same as any other third-party medical insurer/carrier. With the creation of this carrier code, the Agency will be able to add NICA's "coverage" to their TPL record in FMMIS.

By assigning the carrier code to the recipient's record, the Agency can then program FMMIS to perform two tasks:

1. When Medicaid providers perform eligibility checks in their provider portal, they will receive results stating that NICA coverage is present under TPL. This will inform the provider to reach out and bill NICA before attempting to bill Medicaid.
2. To deny Medicaid provider claims explaining "Recipient has other insurance coverage on Medicaid Third Party file. Please file with other carrier or attach insurance company denial". Then providers will need to bill NICA prior to billing Medicaid. If NICA denies their claim, the provider can attach their denial letter and then submit a claim to Medicaid for adjudication.

Prospective Medicaid Lien/Claim Recovery:

When a Medicaid recipient has suffered a birth-related neurological injury, NICA may be liable for his or her medical care. The recipient (through his or her parents or guardians) must petition DOAH to determine whether the claim is NICA compensable. When a family files a petition with DOAH, the Agency is notified. The claimant is required to furnish to NICA any documentation of related expenses and services incurred to date which identifies any payment made for such expenses and services and the payor. They are also required to document any applicable private or governmental source of services or reimbursement relative to the impairments.

A NICA award through the DOAH proceeding includes up to $250,000 to the family for what are effectively non-economic damages. Additionally, they are provided coverage for all medical care related to the neurological injury. The compensation for medical care expressly excludes state-run programs, but not if that exclusion is prohibited by federal law. Because the Medicaid program is the payer of last resort under federal law, NICA cannot exclude compensation for what Medicaid has paid. The Agency thus has a potential claim for reimbursement under the NICA statute; however, there is no provision that specifically provides for the Agency to be repaid. The Agency or SMMC plan can attempt to intervene as a subrogee/assignee/lienholder in the NICA DOAH proceeding of each Medicaid recipient under section 409.910(11), Florida Statutes, which provides in pertinent part that the Agency can intervene in or join any administrative proceeding in its own name individually, as subrogee of a recipient, as assignee of a recipient, or as lienholder.

NICA

SUPPORTIVE SERVICES FOR
FAMILIES & PHYSICIANS

November 1, 2021

The Honorable Wilton Simpson
Room 409 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Simpson:

Pursuant to Sec. 766.315, F.S. attached is the report of the Florida Birth-Related Neurological Injury Compensation Association to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Financial Officer. The report includes all of the data and recommendations specified in that section. The report was reviewed and approved by the Board of Directors at its meeting on October 28, 2021.

Please let me know if you have any questions.

Sincerely,

Jim DeBeaugrine
Chair of the Board of Directors

Florida Birth-Related Neurological Injury Compensation Association
PO Box 14567 - Tallahassee, Florida 32317-4567 - 850-488-8191
Facsimile 850-922-5369 - www.nica.com

NOVEMBER 2021

Report of the Florida Birth-Related Neurological Injury Compensation Association to the Governor, Legislature, and Chief Financial Officer

NICA

In 1988, in response to steeply increasing medical malpractice insurance premiums, the Florida Legislature created the Florida Birth-Related Neurological Injury Compensation Plan (the Plan) as a no-fault program to cover catastrophic birth-related injuries. The Plan is administered by the Florida Birth-Related Neurological Injury Compensation Association (NICA). The Plan was designed to cover a very narrow range and number of injuries that are significant in terms of cost and system impact as they represent outliers and "uninsurable" injuries.

Awards made through NICA are exclusive. If an injury is covered by NICA, the child and his/her family are not entitled to compensation through lawsuits. The cost of lifetime care for covered children is paid by NICA without assessment of fault and with no cap.

In 2021 the Legislature passed SB 1786 which provided additional benefits to the families, changed the structure of the Board of Directors and requires additional protections and oversight to assure that the children and families served by NICA understand and receive all of the benefits available to them. This report required under Sec. 766.315 enhances the transparency needed by policymakers and families as they monitor and evaluate whether NICA is operating in a manner that meets the standards established under the revised legislation.

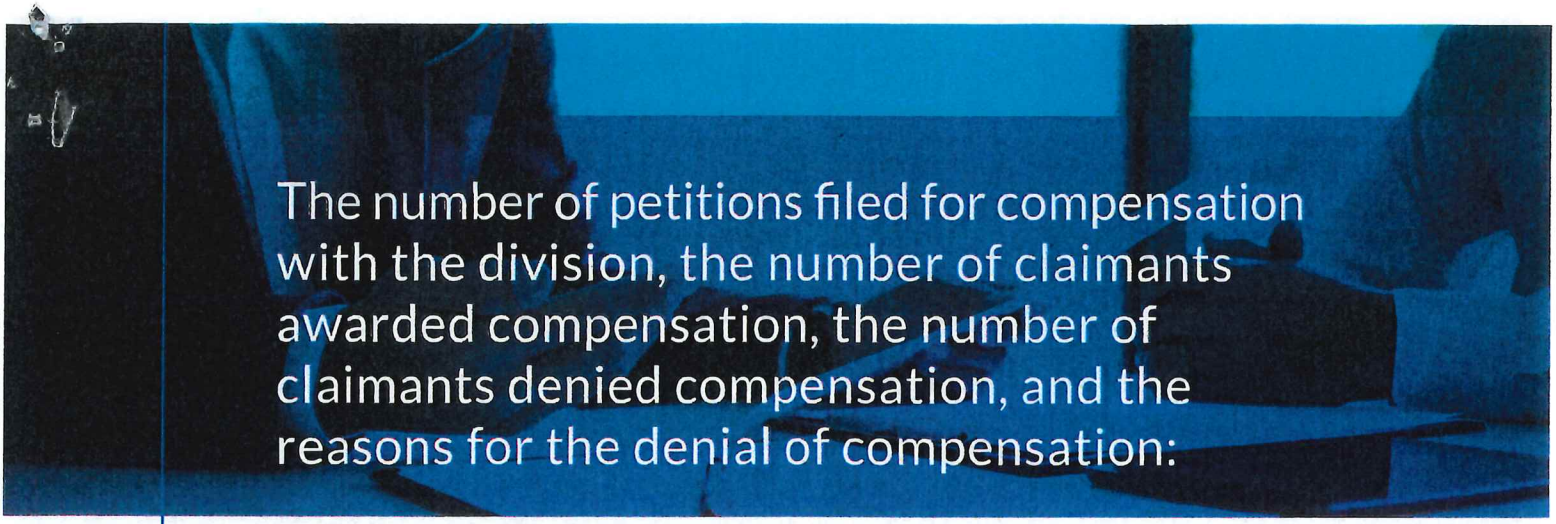
SB 1786 specifically requires that on or before November 1, 2021, and by each November 1 thereafter, the association shall submit a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Financial Officer.

The report must include:

- The number of petitions filed for compensation with the division, the number of claimants awarded compensation, the number of claimants denied compensation, and the reasons for the denial of compensation.
- The number and dollar amount of paid and denied compensation for expenses by category and the reasons for any denied compensation for expenses by category.
- The average turnaround time for paying or denying compensation for expenses.
- Legislative recommendations to improve the program.
- A summary of any pending or resolved litigation during the year which affects the plan.
- The amount of compensation paid to each association employee or member of the board of directors.

For the initial report due on or before November 1, 2021, an actuarial report conducted by an independent actuary which provides an analysis of the estimated costs of implementing the following changes to the plan:

- Reducing the minimum birth weight eligibility for a participant in the plan from 2,500 grams to 2,000 grams.
- Revising the eligibility for participation in the plan by providing that an infant must be permanently and substantially mentally or physically impaired, rather than permanently and substantially mentally and physically impaired.
- Increasing the annual special benefit or quality of life benefit from $500 to $2,500 per calendar year.



The number of petitions filed for compensation with the division, the number of claimants awarded compensation, the number of claimants denied compensation, and the reasons for the denial of compensation:

All NICA claims are presented to an Administrative Law Judge for a determination of compensability under the Plan. The Administrative Law Judge has exclusive jurisdiction to determine whether a claim is compensable.

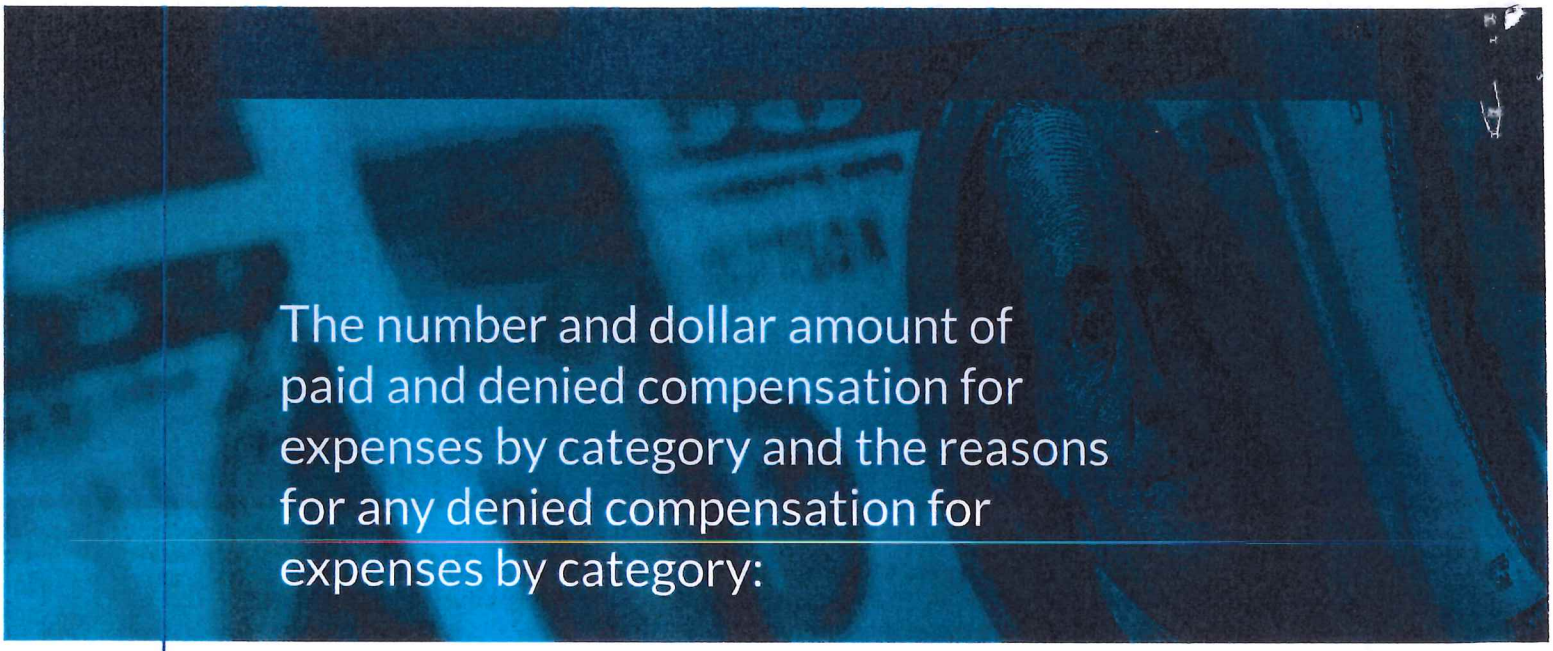
Total number of active NICA participants receiving benefits as of June 30, 2021	219
Number of petitions filed with the Division of Administrative Hearings 7/1/2020-6/30/2021	46

To calculate the number of claimants awarded compensation and the number of claimants denied compensation, claims for which a final order was issued from 7/1/2020 – 6/30/2021 were reviewed. These claims may have been filed in an earlier year but the final order was issued in the fiscal year ending 6/30/2021.

Number of claimants awarded compensation	15
Number of claimants denied compensation	32

Denied claims were ruled non-compensable by an Administrative Law Judge.

Reason for Denial of Compensation	TOTAL
Below minimum threshold weight requirement	2
Did not occur during labor, delivery or the immediate post-delivery period	8
Did not suffer a permanent and substantial mental and physical impairment	13
No identifyable injury at birth, or substantial mental and physical impairments	1
No Oxygen Deprivation	2
No Oxygen Deprivation/No Permanent or Substantial Mental or Physical Impairment	1
Petitioners Elected Remedy-Declining NICA Benefits	1
Physician non-participating	1
Settlement in Circuit Court	1
Withdrawn by Petitioners	2
TOTAL	**32**



The number and dollar amount of paid and denied compensation for expenses by category and the reasons for any denied compensation for expenses by category:

Paid Compensation for Expenses

Category	Number	$ Amount
Custodial Day Care	19	24,215.37
Death Benefit	13	290,000.00
Drugs	439	276,079.40
Equipment	182	395,897.18
Health Insurance Premiums	762	238,944.31
Housing	17	278,340.61
Hospitalizations	2	28,290.98
Nursing Care by Other	1,744	2,513,729.54
Nursing Care by Parent	3,216	14,528,726.02
Other	994	34,472.77
Parental Award	313	28,250,279.40
Physician Charges	256	61,264.31
Supplies	2,071	471,224.96
Therapy	1,032	317,592.43
Transportation & Travel	110	70,501.34
Transportation-Insurance	294	184,513.70
Transportation-Maintenance	293	78,905.50
Transportation-Mileage	803	67,504.44
Transportation-Purchase	119	1,026,178.90
	12,834	**49,136,661.16**

Denied Compensation for Expenses:

Claims Denials

NICA receives many communications from families relative to benefits. For the purposes of reviewing, monitoring and quantifying denials the criteria below are used:

1. Inquiry – A contact requesting information on a possible benefit or coverage that may be available. Some general information may be included such as asking if a particular item might be covered or if a limitation exists. Most of these will be a question as to whether a type of therapy or piece of equipment or treatment is covered. A response to this kind of question may be included in the report for this year in an abundance of caution. In future reports these will not be included in denials but will be viewed and recorded separately in the system and reported as such.

2. Request for Payment or Benefit - A request for benefit or payment must be in writing and include sufficient information to identify the item or service, a receipt, estimate or cost comparison, and a Letter of Medical Necessity (LMN). An Explanation of Benefits or a direction to pay either the vendor or the family must also be included. A communication that does not include all of the required elements in writing will be considered an inquiry and not included in the Denials section of the Report. Only a complete request for benefit or payment will be evaluated and reported if it is denied.

Category	Type	Reason for Denial	Number	$ Amount
Drugs	Denial	Not related to birth-related neurological injury	1	30.00
Other	Denial	Exceeded NICA authorized amount.	2	4,152.79
Other	Denial	Initially denied, resolved.	1	120.28
Other	Denial	NICA requested supporting documentation, none received.	1	25.00
Other	Denial	Not a covered expense	1	1,481.94
Other	Denial	Not related to birth-related neurological injury	1	31.25
Other	Inquiry	Inquiry - Initially denied, possibly covered under SB 1786	1	-
Other	Inquiry	Inquiry - Not related to birth-related neurological injury	1	-
Other	Inquiry	Not a covered expense	1	-
Physician Charges	Denial	Not related to birth-related neurological injury	2	345.00
Therapy	Denial	Not related to birth-related neurological injury	1	-

Transportation - Purchase	Denial	Didn't meet requirements for van pursuant to benefit handbook (prior to SB 1786)	1	-
Transportation/ Travel	Denial	Exceeded NICA authorized amount.	1	1,679.04
Transportation/ Travel	Denial	Not related to birth-related neurological injury	1	477.09
Transportation/ Travel	Inquiry	Inquiry - no supporting documentation received.	1	-
Grand Total			17	8,342.39

The average turnaround time for paying or denying compensation for expenses:

2.5 business days (See Appendix B for detailed analysis.)

Legislative recommendations to improve the program.

The major changes made in SB 1786 will have a number of financial and operational impacts. The costs of the new benefits will need to be fully analyzed and their effect on the actuarial soundness of the plan quantified to assure that NICA continues to be actuarially sound into the future. How the implementation of the new benefits works to resolve many of the issues raised by families should also be evaluated before additional changes are made, other than any technical correction that may be needed. NICA recommends no additional legislative changes be made in the 2022 legislative session, and that a full cost/benefit analysis be included with additional recommendations to be included in the report due November 1, 2022.

A summary of any pending or resolved litigation during the year which affects the plan:

United States of America ex rel. Arven et al. v. The Florida Birth-Related Neurological Injury Compensation Association et al., No. 19-CV-61053-WPD (S.D. Fla 2019)

NICA is a defendant in a federal lawsuit styled United States of America ex rel. Arven et al. v. The Florida Birth-Related Neurological Injury Compensation Association et al., No. 19-CV-61053-WPD (S.D. Fla 2019). Two relators allege in the foregoing qui tam action that NICA violated the federal false claims act ("FCA"), 31 U.S.C. § 3729 et seq., by treating itself as the "payor of last resort" vis-à-vis Medicaid. The United States filed a notice advising the district court that it is not intervening in the case but will continue an investigation into the issues. NICA moved to dismiss the amended complaint on several grounds, including, without limitation (i) the Plan lacks the capacity to be sued, (ii) NICA is immune from suit under the Eleventh Amendment, (iii) NICA is not a third-party under 42 U.S.C. § 1396a(a)(25)(A), and (iv) NICA is not a "person" under the FCA. The district court denied NICA's motion, after which NICA appealed the decision to the United States Court of Appeals for the Eleventh Circuit. The appeal is fully briefed and NICA is awaiting a decision or a notice of oral argument. Meanwhile, the lawsuit is stayed pending resolution of the appeal.

The amount of compensation paid to each association employee or member of the board of directors:

Employee	Total Salary	
Executive Director	177,580.49	
Deputy Director	117,871.78	
Claims Manager	70,438.31	
Case Manager Supervisor	69,495.95	
Case Manager	66,737.19	
Case Manager	64,807.98	
Case Manager	61,911.49	
Case Manager	56,184.96	
Case Manager	40,825.72	*
Case Manager	33,498.20	*
Office Operations Manager	60,710.55	
Accounting Administrator	53,530.40	
Insurance Administrator	54,875.15	
Insurance Administrator	53,481.82	
Provider Relations Coordinator	42,243.64	
Administrative Assistant	37,128.51	
Regulatory Analyst	25,056.29	*

* part time employee

1 Fiscal year ending 6/30/2021

Pursuant to Florida Statutes, members of the NICA Board of Directors serve without salary.

For the initial report due on or before November 1, 2021, an actuarial report conducted by an independent actuary which provides an analysis of the estimated costs of implementing the following changes to the plan:

- Reducing the minimum birth weight eligibility for a participant in the plan from 2,500 grams to 2,000 grams.
- Revising the eligibility for participation in the plan by providing that an infant must be permanently and substantially mentally or physically impaired, rather than permanently and substantially mentally and physically impaired.
- Increasing the annual special benefit or quality of life benefit from $500 to $2,500 per calendar year.

Information reproduced from report by Turner Consulting. See full report in Appendix A.

Summary of Estimated Annual Impact of SB 1786 - Section 5 (8g) Modifications - Relative to Current Revenue and Expense

I. Estimated Current Revenue - 2022 Birth Year (a)	32,000,000
II. Annual NICA Expense - Other than Direct Claims Expense (b)	2,700,000
III. Estimated 2022 Birth Year Level Ultimate Losses - After Inflation and Investment Income Offset (Discount) (c)	59,302,950
IV. Estimated 2022 Amortization of Discount on Present Value Reserves (d)	54,053,935
V. Indicated Profit / (Loss) Based on Current NICA Coverage Terms - Prior to Offset Related to Investment Results I - II - III - IV	(84,056,885)

Indicated Increase in the Annual NICA 2022 Birth Year Expense Shown Above (Item III)

VI. Additional **Annual** Expense (After Anticipated Inflation and Investment Income) Related to Modifications - **2022 BY Level** Modifications Described in Senate Bill 1786 - Section 5 (8g) - Each Assumed to Apply Independently	
A. Item I - Reduction in BW Eligibility From 2,500 grams to 2,000 grams (e)	25,059,035
B. Item II - Change in Impairment from Mental and Physical to Mental or Physical (e)	51,800,388
C. Item III - Increase in Annual Special Benefit from Current $ 500 to $ 2,500 per Calendar Year (e)	368,992
VII. One Time Addition to Prior Year NICA Loss Reserves - Due to Increase in Benefit in Prior Claimants. Related to Increase in the Annual Special Benefit - Reserves as of June 30, 2021 (f)	7,786,484

Notes:(a) Based on latest available annual assessment revenue of $ 31,799,087 as supplied by NICA. Rounded to $ 32.0 Million.
(b) Based on an average of the actual NICA expenses provided for the latest five years.
(c) See Exhibit II, Sheet 1, Item 3a.
(d) Estimate based on application of the 5 % investment assumption included in the NICA loss and LAE reserves evaluated as of June 30, 2021. (i.e. 1,081,078,695 X .05 = $ 54,053,935).
(e) See Exhibit I, Sheet 2, Items I, II and III - B.
(f) See Exhibit I, Sheet 2, Items III - A.

APPENDIX A

Actuarial Analysis of the Estimated Costs of Implementing the Three Potential Changes as Specified in Section 5 (8) (G) of Senate Bill 1786. Prepared by Turner Consulting, Inc., Reviewed by Madison Consulting Group (Appendix A)

MADISON CONSULTING GROUP
Actuaries • Property/Casualty Consulting Services

October 21, 2021

Ms. Kenney Shipley
Executive Director
Florida Birth Related Neurological
Injury Compensation Association
2360 Christopher Place, Suite 1
Tallahassee, Florida 32308

Re: Turner Report on Additional Benefit Option

Dear Ms. Shipley:

At your request I have reviewed the analysis of the cost estimates for three potential benefit changes performed by Turner Consulting (Turner). This letter describes the results of that review.

Qualifications

I conducted the review. I am a Fellow of the Casualty Actuarial Society, a Member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions contained in this letter.

Background

Turner estimated the costs for three potential changes specified in SB 1786. The three changes are:

1. Decreasing the minimum birthweight from 2,500 grams to 2,000 grams.
2. Revising the eligibility standard from physical and mental impairment, to physical or mental impairment.
3. Increasing the quality-of-life (QOL) benefit from $500 to $2,500 per year.

200 N. Second Street • Madison, GA 30650 14 Clover Lane • Newtown Square, PA 19073
706-342-7750 www.madisoninc.com Fax: 706-342-7775

Fallback $10M Reg. TF

Caveat

Turner's analysis, and the analysis in this letter, reflect all changes under SB 1786 except possible changes in the interaction between Medicaid and NICA that are currently under consideration by senior public officials. Until decisions on these matters have been made, they cannot be quantified. We do, however, note that should the final decision result in NICA reimbursing Medicaid for payments it previously made, this would reduce the assets of NICA and reduce its ability to fund ongoing obligations to existing and future claimants compared to the projections in this letter. Additionally, should the final decision increase NICA's responsibility for future payments this too will increase NICA's costs. **We recommend Turner's projections and those contained in this letter be revisited once the situation with Medicaid is settled.**

Conclusions

Turner's Methodology: I have reviewed Turner's report and methodology and believe it is reasonable and consistent with NICA's prior experience and other available sources.

Turner used medical studies and summaries of birth statistics to estimate the additional number of claims that result from changes to benefit eligibility. The results for each of the eight possible options for eligibility/benefit changes are as follows:

1: ESTIMATED ADDITIONAL CLAIMANTS PER BIRTH YEAR				
Option	Reduced Birth Weight	Change Standard to "or"	Increase QOL Benefit	New Claims Per Year
1	Yes	No	No	8.5
2	No	Yes	No	21.7
3	Yes	Yes	No	50.8
4	No	No	Yes	-
5	Yes	Yes	Yes	50.8
6	Yes	No	Yes	8.5
7	No	Yes	Yes	21.7
8	No	No	No	-

Considering that NICA currently accepts an average of about 20 claims per year, any of the scenarios that include a change in the eligibility standard from "and" to "or" are expected to result in a doubling or tripling, in the average number of new claims for every future year.

Turner then estimated the dollar cost for these claims based on the average cost of NICA's current claims, reduced based on his expectation that lower birthweight children may have reduced life expectancy, and that additional claimants from the "or" standard may require less services than those based on the current "and" standard but may have higher life expectancies. This resulted in the following estimates of additional expenses:

2: ESTIMATED ADDITIONAL COST PER BIRTH YEAR ($M)					
				Additional Expense	
Option	Reduced Birth Weight	Change Standard to "or"	Increase QOL Benefit	One Time	Ongoing Annual
1	Yes	No	No	$ -	$ 25.1
2	No	Yes	No	-	51.8
3	Yes	Yes	No	-	132.1
4	No	No	Yes	7.8	0.4
5	Yes	Yes	Yes	7.8	132.9
6	Yes	No	Yes	7.8	25.5
7	No	Yes	Yes	7.8	52.4
8	No	No	No	-	-

In the table above, the "one time" additional expense reflects the cost of the QOL benefit change as it applies to all existing open claims. The ongoing annual expense reflects the annual cost of the benefit change and it will apply year after year. For example, under Scenario 3, the annual cost is $132.1 million. Over the next five years, the expected cost is $660.5 million (= $132.1 x 5 million) plus an inflation adjustment.

Implications of Turner's Cost Estimates

NICA's balance sheet consists of invested assets, a liability (referred to as claim reserve) for future payments to existing claimants, several relatively minor accrual items for assets and liabilities and an item referred to as "net position" that reflects the difference between assets and liabilities. For discussion purposes, the balance sheet can be simplified by netting the accrued items against each other. The preliminary version of the June 30, 2021 balance sheet, so simplified, is ($ Millions):

Assets		**Liabilities and Net Position**	
		Claims Reserve (Liability)	$1,184.5
		Net Position	509.8
Total	$1,694.3	Total	$1,694.3

To ensure that the program is actuarially funded and that there are adequate assets to provide lifetime benefits to the existing claimants, the net position must be greater than $0. To ensure the program is sustainable, the net position should be large enough to absorb potential fluctuations in NICA's investment portfolio. For example, should the market value of its investments fall by 15% (as it has on occasion done in the past) the net position on the balance sheet above would be reduced by $254 million (= $1,694.3 x 15%).

The finances of NICA are highly dependent on the rate of inflation and the rate of investment return on its assets and, most importantly, on the difference between the two. In the recent past, NICA's investment returns have been high (on average about 9% per year since 2010) while inflation in its claim costs have been low (on average about 0.5% per year for the since 2010). This extremely favorable environment (where investment returns exceeded inflation by about 8.5% per year) caused NICA's net position to improve from -$23.8 million to +$509.8 million between June 30, 2009 and June 30, 2021.

By historical standards, the inflation/investment environment since 2009 has been extraordinary. While it has created a very strong balance sheet for NICA, we do not believe

it is likely or prudent to suppose this will extend into the future. For planning purposes and to evaluate the multi-year impact of the proposed benefit changes, we recommend considering two scenarios for future investment/inflation:

Base Scenario: A 2.5% differential between investment return and inflation using inflation of 2% and investment return of 4.5%. A 2.5% differential was implicit in the data provided to us late last year by NICA's investment advisors based on their economic projections for the next 10 years and the current investment strategy.

Optimistic Scenario: A 4% differential between investment return and inflation using inflation of 3% and investment return of 7%. A 4% differential is indicated by long-term (i.e., 1926 and subsequent) returns and inflation applied to a model portfolio.

Pessimistic Scenario: A 1% differential between investment return and inflation using inflation of 5% and investment return of 6%. A 1% differential reflects average 10 year returns for a model portfolio experienced in the 1970's.

We used these scenarios to project NICA's balance sheet out until June 30, 2031. Based on this – summarized in the tables below - we concluded:

1. The status-quo (Option 8) or increasing the QOL benefit alone (Option 4) are likely sustainable without increasing assessment rates. In the pessimistic scenario the net position is decreased by 50% or more but is still positive.

2. Increasing the eligibility with reduced birthweight only is possibly sustainable without substantial increases in assessment rates (Options 1 or 6). The net position does however become negative in the pessimistic scenario.

3. Any of the options that involve the standard of "or" (I.e., Options 2,3,5,7) are unlikely to be sustainable without substantially increasing assessment rates or introducing other funding sources.

3: BASE SCENARIO EXPECTED BALANCE SHEET OUTCOMES ($M)						
Base Scenario:		Inflation =	2.0%	Investment Return =		4.5%
	Reduced	Change	Increase	Net Position		
Option	Birth Weight	Standard to "or"	QOL Benefit	(Actual) 6/30/2021	(Projected) 6/30/2026	(Projected) 6/30/2031
1	Yes	No	No	$ 509.8	$ 398.2	$ 199.2
2	No	Yes	No	509.8	243.2	(173.8)
3	Yes	Yes	No	509.8	(221.9)	(1,293.5)
4	No	No	Yes	509.8	532.4	533.4
5	Yes	Yes	Yes	509.8	(235.2)	(1,314.2)
6	Yes	No	Yes	509.8	386.7	182.8
7	No	Yes	Yes	509.8	231.1	(191.9)
8	No	No	No	509.8	543.4	548.8

4: OPTIMISTIC SCENARIO EXPECTED BALANCE SHEET OUTCOMES ($M)						
Optimistic Scenario:		Inflation =	3.0%	Investment Return =		7.0%
	Reduced	Change	Increase	Net Position		
Option	Birth Weight	Standard to "or"	QOL Benefit	(Actual) 6/30/2021	(Projected) 6/30/2026	(Projected) 6/30/2031
1	Yes	No	No	$ 509.8	$ 582.7	$ 649.4
2	No	Yes	No	509.8	421.6	241.8
3	Yes	Yes	No	509.8	(61.8)	(981.4)
4	No	No	Yes	509.8	722.2	1,014.6
5	Yes	Yes	Yes	509.8	(75.5)	(1,003.6)
6	Yes	No	Yes	509.8	570.8	631.6
7	No	Yes	Yes	509.8	409.1	222.4
8	No	No	No	509.8	733.6	1,031.2

Likely sustainable with no indrease in assessment rate.
Possibly sustainable without substantial increases in assessment rate.
Not sustainable without a substantial increase in revenue

Please let me know if you have any questions or comments

Mark Crawshaw, Ph.D., FCAS, MAAA
Madison Consulting Group, Inc.
200 N. Second Street
Madison, GA 30650
706-342-7750
mark.crawshaw@madisoninc.com

FLORIDA BIRTH RELATED NEUROLOGICAL INJURY COMPENSATION ASSOCIATION
REVIEW OF THREE POTENTIAL CHANGES AS SPECIFIED IN SECTION 5 (8) (g) of SENATE BILL 1786

Turner Consulting, Inc.
October, 2021

TURNER CONSULTING, INC.
CONSULTANTS AND ACTUARIES

125 Clairemont Avenue
Suite 540
Decatur, Georgia 30030
(404) 373-2326
Fax (404) 373-2311

October 18, 2021

Ms. Kenney Shipley
Executive Director
Florida Birth Related Neurological
Injury Compensation Association
2360 Christopher Place, Suite 1
Tallahassee, Florida 32308

Re: Senate Bill 1786 – Section 5 (8) (g) – Analysis of Three Items

Dear Ms. Shipley:

Please find enclosed our report on the analysis of estimated losses related to the three potential changes described in Section 5 (8) (g) of Senate Bill 1786 and listed below.

(1) A reduction in the minimum birth weight eligibility from 2,500 to 2,000 grams
(2) A revision in the eligibility for participation from permanently and substantially mentally **and** physically impaired to permanently and substantially mentally **or** physically impaired
(3) An increase in the annual special benefit or quality of life benefit from $ 500 to $ 2,500 per calendar year.

The estimated cost related to items (1) and (2) are expressed on a present value basis after inflation and discount as if applied to 2022 birth year level NICA claims. The estimated cost related to item (3) are expressed separately as if applied to open and unreported NICA claims as of June 30, 2021 and also as if applied only to 2022 birth year claims.

We have enjoyed working with you on this project and look forward to discussing any questions or comments you may have.

Sincerely,

George W. Turner Jr.
Fellow of the Casualty Actuarial Society,
Member of the American Academy of Actuaries

FLORIDA BIRTH RELATED NEUROLOGICAL INJURY ASSOCIATION
REVIEW OF SENATE BILL 1786 SECTION 5 (8G)

Table of Contents

Purpose

Turner Consulting, Inc. (Turner Consulting) was requested by the Florida Birth Related Neurological Injury Compensation Association (NICA) to estimate costs related to the implementation of three proposed changes to the Florida Birth Related Neurological Injury Compensation Plan (Plan) as specified in Section 5 (8g) of the recently enacted Senate Bill 1786 (SB 1786). The three changes proposed in this section of SB 1786 are as follow.

(1) Reduction in the minimum birth weight eligibility from 2,500 to 2,000 grams

(2) Revision in the eligibility for participation from the current permanently and substantially mentally **and** physically impaired to the modified provision of permanently and substantially mentally **or** physically impaired

(3) Increasing the annual special benefit or quality of life benefit from $ 500 to $ 2,500 per calendar year.

The objective of this report is to estimate the additional cost associated with the two different modifications (expansions) to the current definition of a "birth related neurological injury" as described in items (1) and (2) above plus the estimated cost related to an increase in the benefit level described in item (3).

The three modifications under consideration result in an expansion of the current claim and benefit levels and thus will result in an increase in the losses (i.e., claim

expenses) incurred by NICA during claim periods after any modification to the current statutes is implemented. The estimates as set forth in this report are developed assuming the modifications apply to claims incurred in birth year 2022. In addition, for the annual special benefit an estimate is provided of the expense related to the application of the change to all NICA open and unreported claims as of June 30, 2021.

The estimates developed for each of the three modifications are calculated independently and thus the implementation of more than one modification at a time will result in an increase in expected losses greater than simply the sum of the increase shown for each modification independently. As an example of the impact of making two changes in combination we included an estimate of the additional cost in the event the modifications described in items (1) and (2) are implemented together. Since the combined implementation will result in the application of the change described in item (2) to the additional claimants in the birth weight range between 2,000 grams and 2,500 grams, the additional cost will be greater than the simple addition of the two independent changes.

Background

NICA was created by Florida Statute to provide care for children beginning in 1989 that meet the birth related injury criteria as defined in Florida Statutes 766.301 to 766.316. The NICA statute replaces the traditional tort liability remedies with a no-fault type system for those children that meet the requirements as defined in the statute. The qualifying child must be severely mentally and physically impaired. In addition, a claim must be filed within five years after birth. Prior to the 1994 birth year, a claim had to be filed within seven years of birth.

Care is provided for the life of the child. Funds are collected from the various medical care providers during each birth year and invested until payments are required on behalf of the qualifying claimants. There are very limited resources for collecting additional funds from the insurance industry and the Florida Office of Insurance Regulation in the event the assessments collected from the medical care providers are not adequate. Due to the significant time expected between when funds are collected and the actual payment of benefits, the estimated impact of inflation and anticipated investment income must be considered in the establishment of ultimate losses on a present value basis.

In May 2021, the Florida Legislature passed Senate Bill 1786 (SB 1786), which resulted in changes to the financial obligations of NICA. Beginning with the June 30, 2021 NICA loss and LAE reserve report, the additional costs related to the explicit changes set forth in Senate Bill 1786 are included. In addition to these explicit changes, SB 1786 includes requirements for the additional study and

potential changes to the allocation of expenses previously and currently paid by Medicaid. Since the final report on Medicaid related expenses is not due until November 1, 2021 any estimate of the cost of this item would be speculative at this time and are not included in the estimates as shown in this report or the loss and LAE reserve estimates included in the most recent NICA loss and LAE report evaluated as of June 30, 2021. Any subsequent revision to the Medicare participation levels will impact both the reserve levels as set forth in the NICA loss and LAE reserve report evaluated as of June 30, 2021 as well as the estimated additional cost for items (1) and (2) as set forth in this report.

Qualifications

I, George W. Turner Jr. am a consulting actuary for Turner Consulting, Inc. I am a Fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries and I meet the Qualification Standards of the American Academy of Actuaries to render the opinions as expressed in this report.

Distribution and Use

This report is intended solely for the internal use of NICA, its Board of Directors, state of Florida officials and advisors. Any further use or distribution of this report is not intended or authorized without our prior written consent.

Conditions and Limitations

In preparing the estimates as shown in this report we relied without audit or verification on the loss, exposure, and expense information as provided to us by responsible employees of NICA We also relied upon available information regarding countrywide and Florida specific birth levels by weight and physician levels by type. Additionally, we relied upon information regarding the number of incidents by category and birth weight as shown in a report prepared by the University of Florida - College of Medicine and various articles on cerebral palsy rates by birth weight range. For certain estimates we include by reference information as shown in our June 30, 2021 report on NICA loss and LAE reserves.

The indicated ultimate loss estimates provided in this report are directly related to the estimates of the additional number of claims (i.e., claim frequency) and the average claim size (i.e., average claim severity) of these additional claims resulting from each of the modifications set forth in Section 5 (8g) of Senate Bill 1786. Estimates of the number and average value of claims expected for a prospective period are subject to a significant degree of uncertainty. This uncertainty arises from the estimation of losses that have yet to occur, and which will be impacted by a number of internal and external factors each subject to uncertainty. An additional element of uncertainty results from the lack of actual historical loss experience for the proposed claim definition modifications. Due to the significant degree of uncertainty there can be no guarantee that actual losses will not vary, perhaps significantly, from the estimates as shown in this report. However, we have, in our

judgement, employed methods and assumptions that are appropriate given the information available.

The additional losses estimated for each of the claim definition modifications do not include any provision for any additional underwriting and / or management expenses that may be incurred by NICA. To the extent any of the changes result in additional NICA administrative expenses the additional cost will need to be added to the estimates as shown in this report.

The estimates shown in this report are based upon our interpretation of the modified coverage language associated with each of the three adjustments described in Section 5 (8g) of Senate Bill 1786. For some of these coverage revisions the final interpretation upon implementation may expand or restrict the actual coverage relative to the understanding used in the estimation of the additional losses as shown in this report. Once the actual coverage wording is selected, the estimates as developed in this report should be refined to reflect any changes to the ultimate loss estimates due to any restriction or expansion of coverage.

Section 7 of Senate Bill 1786 includes a provision for the review of Medicaid third-party liability functions and rights under 2. 766.31, Florida Statutes, relative to the Plan. Based on the findings of this review a report is to be provided to the President of the Senate, Speaker of the House and Chief Financial Officer regarding the

extent and value of liabilities owed by the Plan. To the extent any changes are made in the participation of Medicaid in expenses related to NICA claimants these changes will need to be considered relative to the estimates as shown in this report.

The additional losses resulting from the modifications under consideration involve the payment of expenses over the remaining life of the claimants and are stated on a present-value basis. This approach assumes that sufficient assets will be available to cover the present value of the ultimate losses indicated. To the extent sufficient assets are not available, the ultimate loss estimates will need to be increased to account for the reduction in anticipated investment income.

The attached exhibits summarizing the assumptions and calculations underlying the estimates set forth in this report are to be considered an integral part of the report. Thus, an accurate understanding of the conclusions as set forth in the report is conditional upon an examination of both the text and the attached exhibits. Further, any distribution of this report should be provided in its entirety and with the understanding that I am available to answer questions regarding the methods and assumptions herein.

Executive Summary

The estimated additional losses as shown in Exhibit I, Sheet 1 are shown on a 2022 birth year level and reflect our estimate of the 2022 expected number of births and provider participation rates. The estimates as shown on this exhibit reflect our estimate of the current NICA expected losses related to expected NICA claims for the 2022 birth year both before and after each of the three modifications described in Section 5 (8g) of SB 1786. The estimate shown for the of the change in the annual special benefit is shown on both a retrospective and prospective basis. That is, this change could be applied to both current open and unreported NICA claimants as well as the new claimants expected for birth year 2022.

Two of the three modifications include consideration of anticipated inflation, mortality and investment income. The third modification, the $ 2,000 increase in the annual special benefit, includes consideration of investment income and mortality only. The inflation and discounts rates used are the same (i.e. 3.50 % and 5.00 %, respectively) as the assumptions currently utilized in the overall NICA loss and LAE reserve estimates.

The additional estimated additional ultimate losses after consideration of anticipated inflation and investment income for the two claim definition modifications during the 2022 birth year are $ 25.06 million and $ 51.80 million for the decrease in birth weight (2,500 grams to 2,000 grams) and the modification in

the mental and physical impairment definition, respectively. As mentioned previously, the increase in the annual special benefit from $ 500 to $ 2,500 is shown for both the open and unreported NICA claimants as of June 30, 2021 as well as for the estimated NICA claimants expected during birth year 2022. The estimated increase required for the open and unreported claimants is $ 7.79 million and the estimate for the 2022 birth year claimants is $ .37 million. Also, as mentioned previously, each of the above estimates is expressed on an independent basis. In the event multiple changes are made in combination, the combined increase will exceed the sum of the increases on an independent basis. For example, an estimate of the expected increase for both claim definition changes made in concert (i.e. items I and II together - decrease in birth weight and the inclusion of either mentally or physically impaired claimants rather than both) is $ 132.07 million rather than the sum of the two independent changes which is $ 76.86 million (i.e. $ 25.06 + $ 51.80). This results from the additional impact of the second change on the additional claimants expected in the birth weight range from 2,000 to 2,500 grams.

Methodology

The estimated additional ultimate losses related to each of the three modifications are expressed as additions to the ultimate losses expected to be incurred in birth year 2022 under the current NICA statute. An estimate of the NICA ultimate losses after inflation and discount for the 2022 birth year before any of the modifications is $ 59.30 million (see Exhibit I, Sheet 1, Item 3). The estimated additional 2022 birth year losses in the event each of the three modifications are made individually (i.e. not in combination) are $ 25.06 million, $ 51.80 million and $ .37 million for modifications I, II and III, respectively (see Exhibit I, Sheet 1, Items VI A, VI B and VI C).

As mentioned previously the estimates referenced above include consideration of the explicit changes set forth in Senate Bill 1786, but do not include any change in the historical Medicaid participation rate on NICA claimants. The estimated additional losses are based upon an estimate of the number of additional incurred claims associated with each of the first two modifications and an estimate of the average claim size associated with each. The estimated additional expense for the annual special benefit increase of $ 2,000 is based on the expected number of claims for birth year 2022 and an estimate of the mortality decrements associated with the average NICA claimant. All estimates are based on an assumed prospective average inflation rate of 3.50 % and an average investment return of

5.00 % per year. The discount for mortality is based on standard mortality tables adjusted to an estimate of NICA historical mortality experience.

The additional number of claims resulting from the birth weight modification and the impairment definition change are expressed as a multiple of the expected claims for birth year 2022 under the current NICA coverage definitions. The estimated number of additional claims resulting each of these two modifications is a multiple of the estimated 2022 NICA claims. The NICA claims expected during the 2022 birth year prior to any coverage changes are estimated based upon a review of the actual accepted NICA claims during the period from 2009 to 2019. A summary of the actual and expected ultimate number of reported claims (accepted) for each birth year is shown in Exhibit VII, Sheet 1 and the number of claims expected during the 2022 birth year are shown in Exhibit III, Sheet 1, Item 5.

The estimated 2022 level average claim size assuming the current NICA coverage definitions does not change is based on a review of actual NICA losses adjusted to estimated 2022 loss levels. The 2022 average claim size for those claimants alive at the time the claim is reported is adjusted to include consideration of prospective inflation, and discount (i.e. discounted for estimated mortality and interest). The historical NICA loss experience used in the estimation of the 2022 level average claim size is from birth years 2000 to 2020. A summary of this

experience and the resulting 2022 level estimate is shown in Exhibit V, Sheets 1 and 2.

The estimated additional ultimate losses resulting from each of the first two modifications under consideration are based on the multiplication of the estimated additional number of claims and the selected average claim size. The average claim size for the additional claims expected as a result of the decrease in the eligible birth weight is not adjusted relative to the current average claim size indicated based on historical NICA loss experience. While it is possible the average claim size for these lower birth weight claimants will vary from the average experienced for the current NICA claimants which are for claimants with birth weights 2,500 grams and above, we are not aware of currently available information that can be used to adequately address the interplay between a likely increased level of impairment for the lower birth weight group and also a likely decrease in the average life expectancy. For the purpose of the current report we have used a modification factor 1.0 applied to for the average claim size based on current NICA experience for the first modification.

In a similar manner we are not aware of available information that will allow for the calculation of an adjustment factor to apply to the average claim size for the second modification (i.e. change in the requirement from both mental and physical impairment to a requirement for either mental or physical impairment). However, since it is very likely the overall impairment level of this group will be less, possibly

by a significant amount on average, we have judgmentally adjusted the average claim size based on the current NICA accepted claim population of both mental and physical impairment by a factor of .80 (i.e. a decrease of 20 %). Once additional study of the differences in life expectancy and benefit levels expected for this population can be investigated this initial estimate should be refined.

The estimated increase in the number of claims related to the decrease in the birth weight eligibility from 2,500 grams to 2,000 grams is based on (1) the current NICA claim frequency per 1,000 births for claimants with a birth weight 2,500 grams and above (2) an estimate of the relationship of the claim frequency for births in the birth weight range from 2,000 to 2,500 grams relative to the claim frequency for birth weights above 2,500 grams, (3) the estimated number of 2022 births in the birth weight range from 2,000 to 2,500 grams, (4) the percent of these births delivered by a NICA participating physician. This calculation which is summarized on Exhibit III, Sheet 1.

The estimate of the current NICA accepted claims per 1,000 births with a birth weight of 2,500 grams and above is based on a review of actual NICA accepted claims per Florida birth 2,500 grams and above adjusted for an estimate of the number of births delivered by a NICA participating physician. A summary of this calculation is shown on Exhibit VII, Sheet 1, Columns (11) and (12).

The second variable mentioned above (i.e. relativity of the claim frequency on the lower birth weight range) is the most uncertain since no actual NICA historical experience exists for the births in the range from 2,000 grams to 2,500 grams. An estimate of this relationship is based on the review of cerebral palsy claim frequency at birth by birth weight range from two sources and also Florida specific data compiled over the period from 1980 to 1989 by the University of Florida College of Medicine. This information is based on neonatal intensive care unit (NICU) admissions for ten of Florida's regional perinatal centers during the period from July 1980 to June 1989. The relationship of the claim frequency in the additional birth weight range to the claim frequency for the birth weights 2,500 grams and above based on the three data sources, as well as the final selected relativity, is summarized in item 6 of Exhibit III, Sheet 1.

The third variable, the estimated 2022 Florida births by birth weight range, is based upon actual Florida births by birth weight range (see Exhibit VII, Sheet 1 and 2) over the period from 2009 to 2019. The final variable, the percent of Florida birth delivered by a NICA participating physician is based on a comparison of actual Florida census information for Florida OB/GYN's, a survey of the percentage of OB/GYN's actually performing deliveries, and the number of NICA participating physicians by year. A summary of the NICA participating physicians to an estimate of the Florida OB/GYN's delivering is shown on Exhibit VIII. The final selected NICA participation rate is 90 %.

A similar approach is used to estimate the increase in the number of accepted NICA claims resulting from the change described in item II of Senate Bill 1786 Section 5 (8g). The expected 2022 NICA claim frequency based on current coverage definitions is developed as described above for item I. The relationship of the claim frequency based on only one of the two currently required mental and physical impairments to the current claim definition requirement of both is probably more uncertain than the estimated increase due to a change in birth weight alone since there is a limited volume of information to use as a basis for the estimate. In addition, any change in the definition of the required level of impairment to satisfy the definition of "permanently and substantially" as stated in the statute when applied to the two components individually (i.e. mental or physical) can significantly impact the overall claim frequency increase. The data we used to estimate the relationship of the additional claims expected due to this change in definition is the claim estimates as shown in the University of Florida – College of Medicine report prepared in 1990. This report included information on birth weight, codes including type of injury information (i.e. resuscitated, asphyxia, mechanical injury and abruption), and for a portion of births independent scores on mental and physical impairment levels (e.g. below a score of 50 or below a score of 70). Based on the information included in this report we developed a ratio of the number of estimated claimants with either mental or physical impairment to those with both mental and physical impairment. As the level of impairment (scores above 50) decreases the relative increase in the number of claimants due to the use of the either requirement increases. Thus, any increase in the score used in the definition of

permanently and substantially will potentially significantly increase the impact of this coverage modification. A summary of the data by birth weight range, injury type, both or either impairment and score range used is shown in Exhibit IV, Sheets 1, 2 and 3.

The third modification mentioned in Section 5 (8g) of the recently enacted Senate Bill 1786, an increase in the annual special benefit from the current $ 500 to $ 2,500 per calendar year can be interpreted as applying to all current NICA open and unreported claimants or just to all new claims reported after a specific date. As written it would appear to indicate an increase of $ 2,000 per calendar year for either or both of the two groups mentioned above. The estimated cost is developed as a present value after consideration of mortality and interest of the additional $ 2,000 per calendar year. The estimated present value cost for all open and unreported NICA claimants evaluated as of June 30, 2021 is developed on Exhibit VI, Sheet 1, Item I (13a). This estimate is based on an estimate of the number or years remaining for all open and unreported claimants as of June 30, 2021. The estimated decrements of all open claimants as of June 30, 2021 is based on an estimate of the decrements as shown in Appendix E of our report on NICA loss and LAE reserves evaluated as of June 30, 2021.

Alternatively, the estimated additional losses related to expected NICA claimants during birth year 2022 are based on expected life expectancy for a claimant born

in 2022 adjusted for the expected reporting lag in the receipt of the actual claim. The estimated increase is developed in Exhibit VI, Sheet 1, Item II 5 a.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit I
Sheet 1

Summary of Estimated Annual Impact of SB 1786 - Section 5 (8g) Modifications - Relative to Current Revenue and Expense

I. Estimated Current Revenue - 2022 Birth Year (a)	32,000,000
II. Annual NICA Expense - Other than Direct Claims Expense (b)	2,700,000
III. Estimated 2022 Birth Year Level Ultimate Losses - After Inflation and Investment Income Offset (Discount) (c)	59,302,950
IV. Estimated 2022 Amortization of Discount on Present Value Reserves (d)	54,053,935
V. Indicated Profit / (Loss) Based on Current NICA Coverage Terms - Prior to Offset Related to Investment Results I - II - III - IV	(84,056,885)

Indicated Increase in the Annual NICA 2022 Birth Year Expense Shown Above (Item III)

VI. Additional **Annual** Expense (After Anticipated Inflation and Investment Income) Related to Modifications - **2022 BY Level** Modifications Described in Senate Bill 1786 - Section 5 (8g) - Each Assumed to Apply Independently	
A. Item I - Reduction in BW Eligibility From 2,500 grams to 2,000 grams (e)	25,059,035
B. Item II - Change in Impairment from Mental and Physical to Mental or Physical (e)	51,800,388
C. Item III - Increase in Annual Special Benefit from Current $ 500 to $ 2,500 per Calendar Year (e)	368,992
VII. One Time Addition to Prior Year NICA Loss Reserves - Due to Increase in Benefit in Prior Claimants. Related to Increase in the Annual Special Benefit - Reserves as of June 30, 2021 (f)	7,786,484

Notes:(a) Based on latest available annual assessment revenue of $ 31,799,087 as supplied by NICA. Rounded to $ 32.0 Million.
(b) Based on an average of the actual NICA expenses provided for the latest five years.
(c) See Exhibit II, Sheet 1, Item 3a.
(d) Estimate based on application of the 5 % investment assumption included in the NICA loss and LAE reserves evaluated as of June 30, 2021. (i.e. 1,081,078,695 X .05 = $ 54,053,935).
(e) See Exhibit I, Sheet 2, Items I, II and III - B.
(f) See Exhibit I, Sheet 2, Items III - A.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit I
Sheet 2

Estimated Increase in Present Value Cost of Three Changes Mentioned in Section 5 (8g) of SB 1786
Estimates Are Stated on a 2022 Level - Prior to Any Changes to Medicare Participation Terms

Amounts shown are estimates of the Increase in Current NICA Cost Prior to Any Change - After Inflation and Discount
Estimates are Shown After Inflation and Investment Income - Assuming Inflation = 3.50 % and Discount = 5.0 % per Annum

I. Item # 1 - Reduction in Minimum Birth Weight Eligibility from 2,500 Grams to 2,000 Grams (a)	25,059,035
II. Item # 2 - Revision in Eligibility from mentally and physically to mentally and / or physically impaired (b) No Change in Birth Weight	51,800,388
III. Item # 3 - Increase in the Annual Special Benefit (Quality of Life) from $ 500 to $ 2,500 per Year **Assumes No Change in Future Benefit Increase due to Inflation**	
A. Increased Cost on Current Open and Unreported Claims as of June 30, 2022 (c)	7,786,484
B. Increase in Annual Cost for 2022 Birth Year Expected Accepted Claims (d)	368,992
Additional Items	
IV. Estimated Impact of Combination of Birth Weight Reduction and Eligibility Requirement (e) Change from "and" to "and/or" - i.e. Items # 1 and # 2 on a Combination Change	132,072,075
V. Item # 3 - Increase in the Annual Special Benefit (Quality of Life) from $ 500 to $ 2,500 per Year Including an Increase in the Benefit Change for the Impact of Inflation	
A. Increased Cost on Current Open and Unreported Claims as of June 30, 2022 (f)	14,841,624
B. Increase in Annual Cost for 2022 Birth Year Expected Accepted Claims (g)	780,094

Notes: (a) See Exhibit II, Sheet 1, Item II. 3 (a).
(b) See Exhibit II, Sheet 2, Item II. 3 (a).
(c) See Exhibit VI, Sheet 1, Item I. 13 a.
(d) See Exhibit VI, Sheet 1, Item II. 5 a.
(e) See Exhibit II, Sheet 3, Item II. 7a.
(f) See Exhibit VI, Sheet 1, Item I. 13 b.
(g) See Exhibit VI, Sheet 1, Item II. 5 b.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit II
Sheet 1

Item # 1 - Estimated Increase in Annual Cost Related to Decrease in Birth Weight Eligibility from Current 2,500 Grams to Alternative of 2,000 Grams

I. Estimated 2022 NICA Ultimate Loss and ALAE - Based on Current Birth Weight (2,500 Grams) and Coverage Trigger - Before any Adjustment to Current Medicare Participation	
1. Estimated 2022 NICA Accepted Claims - Current Birth Weight and Claim Trigger (i.e. "and" Only) (a)	
a. All Accepted - Includes Deceased Prior to Acceptance	20.03
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	14.56
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	5.46
2. Estimated 2022 NICA Average Claim Size - After Inflation and Discount (b)	
a. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	3,950,000
b. Accepted Claims - Deceased Prior to Acceptance	325,000
3. Estimated 2022 NICA Ultimate Loss and ALAE - Based on Current Birth Weight (2,500 Grams) and Coverage Trigger - Before any Adjustment to Current Medicare Participation	
a. All Accepted - Includes Deceased Prior to Acceptance = (3a) + (3b)	59,302,950
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = (1b) X (2a)	57,527,958
c. Accepted Claims - Deceased Prior to Acceptance = (1c) X (2b)	1,774,992
II. Estimated Increase in 2022 NICA Ultimate Loss and ALAE Related to Inclusion of Birth Weight Range 2000 to 2,499 Grams and Coverage Trigger - Before any Adjustment to Current Medicare Participation	
1. Estimated Increase in 2022 NICA Accepted Claims - Due to Reduction in Birth Weight Alone (c)	
a. All Accepted - Includes Deceased Prior to Acceptance	8.46
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	6.15
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	2.31
2. Estimated Relativity of Average Claim Cost - Birth Weight Range 2,000 to 2,499 to Range 2,500 and Above (d)	1.00
3. Estimated Increase in 2022 NICA Ultimate Loss and ALAE Due to Reduction in Birth Weight Eligibility to 2,000 Grams and Coverage Trigger - Before any Adjustment to Current Medicare Participation	
a. All Accepted - Includes Deceased Prior to Acceptance = (3a) + (3b)	25,059,035
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = (II.1b) X (2) X (I.2a)	24,308,995
c. Accepted Claims - Deceased Prior to Acceptance = (II.1c) X (I.2b)	750,040

Notes: (a) See Exhibit III, Sheet 1, Item 5.
(b) See Exhibit V, Sheet 1, Items (8) and (9)
(c) See Exhibit III, Sheet 1, Item (8).
(d) We are not aware of data available to form a basis for a change in the average estimated claim size for those claims with with lower birth weight i.e. range from 2,000 to 2,500 grams. While it is likely on average these claimants will be more severely impaired a translation to higher cost is more difficult due to the interplay of mortality expectations.

Item # 2 - Estimated Increase in Annual Cost Related to Change in Coverage Trigger from Permanently and Substantially Mentally "and" Physically Impaired to Mentally "and / or" Physically Impaired

Change in Coverage Trigger Only - No Change in Birth Weight Eligibility

I. Estimated 2022 NICA Ultimate Loss and ALAE - Based on Current Birth Weight (2,500 Grams) and Coverage Trigger - Before any Adjustment to Current Medicare Participation	
1. Estimated 2022 NICA Accepted Claims - Current Birth Weight and Claim Trigger (i.e. "and" Only) (a)	
a. All Accepted - Includes Deceased Prior to Acceptance	20.03
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	14.56
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	5.46
2. Estimated 2022 NICA Average Claim Size - After Inflation and Discount (b)	
a. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	3,950,000
b. Accepted Claims - Deceased Prior to Acceptance	325,000
3. Estimated 2022 NICA Ultimate Loss and ALAE - Based on Current Birth Weight (2,500 Grams) and Coverage Trigger - Before any Adjustment to Current Medicare Participation	
a. All Accepted - Includes Deceased Prior to Acceptance = (3a) + (3b)	59,302,950
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = (1b) X (2a)	57,527,958
c. Accepted Claims - Deceased Prior to Acceptance = (1c) X (2b)	1,774,992
II. Estimated Increase in 2022 NICA Ultimate Loss and ALAE Related Change in Coverage Trigger from Mentally "and" Physically to Mentally "and/or" Physically Impaired - No Change in Birth Weight Eligibility	
1. Estimated Increase in 2022 NICA Accepted Claims Due to Change in Coverage Trigger Only (c)	
a. All Accepted - Includes Deceased Prior to Acceptance	21.70
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	15.78
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	5.92
2. Estimated Relativity of Average Claim Cost - Claimants with either mental or physical impairment to those with both mental and physical impairment. (d)	0.80
3. Estimated Increase in 2022 NICA Ultimate Loss and ALAE Related to Change in Coverage Trigger from "And" to "And/or" - No Change in Birth Weight	
a. All Accepted - Includes Deceased Prior to Acceptance = (3a) + (3b)	51,800,388
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = (II.1b) X (2) X (I.2a)	49,876,740
c. Accepted Claims - Deceased Prior to Acceptance = (II.1c) X (I.2b)	1,923,648

Notes: (a) See Exhibit III, Sheet 1, Item 5.
(b) See Exhibit V, Sheet 1, Items (8) and (9)
(c) See Exhibit III, Sheet 2, Item 3. Col. (5)
(d) We are not aware of data available to form a basis for a change in the average estimated claim size for those claims with either mental or physical impairment relative to those with both. It is likely on average these (i.e. either) claimants will be less severely impaired a translation to lower cost is difficult to quantify based on the data currently available. We have judgementally adjusted the average claim size downwards by 20 % until additional study can be made.

Estimated Increase in After Inflation / Discount Ultimate Loss and ALAE - 2022 Birth Year Level
Combination of Changes Described in Items # 1 and # 2 - Reduction in Birth Weight and Change in Coverage Trigger

Change in Coverage Trigger and Reduction in Birth Weight Eligibility

I. Estimated 2022 NICA Ultimate Loss and ALAE - Based on Current Birth Weight (2,500 Grams) and Coverage Trigger - Before any Adjustment to Current Medicare Participation	
1. Estimated 2022 NICA Accepted Claims - Current Birth Weight and Claim Trigger (i.e. "and" Only) (a)	
a. All Accepted - Includes Deceased Prior to Acceptance	20.03
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	14.56
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	5.46
2. Estimated 2022 NICA Average Claim Size - After Inflation and Discount (b)	
a. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	3,950,000
b. Accepted Claims - Deceased Prior to Acceptance	325,000
3. Estimated 2022 NICA Ultimate Loss and ALAE - Based on Current Birth Weight (2,500 Grams) and Coverage Trigger - Before any Adjustment to Current Medicare Participation	
a. All Accepted - Includes Deceased Prior to Acceptance = (3a) + (3b)	59,302,950
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = (1b) X (2a)	57,527,958
c. Accepted Claims - Deceased Prior to Acceptance = (1c) X (2b)	1,774,992
II. Estimated Increase in 2022 NICA Ultimate Loss and ALAE Related Change in Coverage Trigger from Mentally "and" Physically to Mentally "and/or" Physically Impaired and Reduction in Birth Weight Combined	
1. Estimated Increase in 2022 NICA Accepted Claims - Birth Weigh Reduction Only (c)	
a. All Accepted - Includes Deceased Prior to Acceptance	8.46
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	6.15
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	2.31
2. Estimated Relativity of Average Claim Cost - Birth Weight Range 2,000 to 2,499 to Range 2,500 and Above (d)	1.00
3. Estimated Increase in 2022 NICA Accepted Claims Due to Change in Coverage Trigger Only - No BW Change (e)	
a. All Accepted - Includes Deceased Prior to Acceptance	21.70
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	15.78
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	5.92
4. Estimated Relativity of Average Claim Cost - Claimants with either mental or physical impairment to those with both mental and physical impairment (f)	0.80
5. Estimated Increase in 2022 NICA Accepted Claims Due to Change in Coverage Trigger on Claims in BW Range from 2,000 to 2,499 (g)	
a. All Accepted - Includes Deceased Prior to Acceptance	20.65
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	15.02
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	5.63
6. Estimated Relativity of Average Claim Cost - Change in Coverage Trigger on Claims with BW Between 2,000 and 2,499 grams (h)	0.90
7. Estimated Increase in 2022 NICA Ultimate Loss and ALAE Related to Change in Coverage Trigger from "And" to "And/or" - No Change in Birth Weight	
a. All Accepted - Includes Deceased Prior to Acceptance = (7a) + (7b)	132,072,075
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = [{(II.1b)X(II.2)}+{(II.3.bX(II.4)}+((II.5b)X(II.6))] X (I.2a)	127,568,288
c. Accepted Claims - Deceased Prior to Acceptance = (II.1c + II. 3c + II. 5c) X (I.2b)	4,503,786

Notes: (a) See Exhibit III, Sheet 1, Item 5.
(b) See Exhibit V, Sheet 1, Items (8) and (9)
(c) See Exhibit III, Sheet 1, Item 8.
(d) We are not aware of data available to form a basis for a change in the average estimated claim size for those claims with with lower birth weight i.e. range from 2,000 to 2,500 grams. While it is likely on average these claimants will be more severely impaired a translation to higher cost is more difficult due to the interplay of mortality expectations.
(e) See Exhibit III, Sheet 2, Item 3. Col. (5)
(f) See Exhibit II, Sheet 2, footnote (d)
(g) See Exhibit III, Sheet 2, Item 3. Col. (6)
(h) We have assumed to likely increase in level of impairment related decrease in birth weigh is partially offset by likely decrease associated with only one impairment and judgementally decreased the average claim size by 10 %.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit III
Sheet 1

Estimated Increase in NICA Claim Frequency Related to Decrease in Birth Weight from
Current Above 2,499 Grams Requirement to Alternative Above 1,999 Grams

2022 Birth Year Estimate

	All Florida Births
	(2)
1. Estimated Florida Births - 2022 (a)	
a. All Birth Weights	221,699
b. Birth Weights - 2,500 & Greater	202,278
c. Birth Weights - 2,000 to 2,499 Grams	12,211
d. Birth Weights - 2,000 & Greater = c. + d.	214,489
2. Estimated Percent of Florida Births Covered by NICA (b)	90.00%
3. Estimated Florida Births Covered by NICA- 2022 (a)	
a. All Birth Weights = (1a.) X (2)	199,529
b. Birth Weights - 2,500 & Greater = (1b.) X (2)	182,051
c. Birth Weights - 2,000 to 2,499 Grams = (1c.) X (2)	10,990
d. Birth Weights - 2,000 & Greater = c. + d.	193,040
4. Estimated NICA Accepted Claim Frequency per 1,000 Births - 2,500 Grams or Greater (c)	
a. All Accepted - Includes Deceased Prior to Acceptance	0.110
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	0.080
5. Estimated 2022 NICA Accepted Claims - Current Birth Weight and Claim Trigger (i.e. "and" Only)	
a. All Accepted - Includes Deceased Prior to Acceptance = [(3b) / 1,000] X (4a)	20.03
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = [(3b.) / 1,000] X (4b)	14.56
c. Accepted Claims - Deceased Prior to Acceptance = (5a.) - (5b.)	5.46
6. Estimated Ratio of Claim Frequency - Births in Range 2,000 to 2,499 Grams to Births Above 2,499 Grams	
a. Based on United Kingdom Study of CP Incidence by Birth Weight - Quadiplegias Only (d)	8.00
b. Based on Atlanta CP By Birth Weight Study - Low Relativity (e)	6.15
c. Based on Atlanta CP By Birth Weight Study - High Relativity (e)	7.89
d. Based on U. of Florida College of Medicine Study (January 1991) (f)	8.50
e. Selected Claim Frequency per 1,000 Births Relativity - 2,000 to 2,499 BW Range to 2,500 and Above BW Range	7.00
7. Indicated NICA Accepted Claim Frequency per 1,000 Births - 2,000 to 2,499 Grams BW Range	
a. All Accepted - Includes Deceased Prior to Acceptance = (4a) X (6e)	0.770
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = (4b) X (6e)	0.560
8. Indicated Additional NICA Accepted Claims Related to a Decrease in BW Threshold from 2,500 Grams to 2,000 Grams	
a. All Accepted - Includes Deceased Prior to Acceptance = [(3c) / 1,000] X (7a)	8.46
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = [(3c) / 1,000] X (7b)	6.15
c. Accepted Claims - Deceased Prior to Acceptance = (8a.) - (8b.)	2.31

Notes: (a) See Exhibit VII, Sheet 2, Items (18A) and (18B).
(b) See Exhibit VIII.
(c) See Exhibit VII, Sheet 1, Columns (11) and (12).
(d) See Exhibit IX, Item (23).
(e) See Exhibit VII, Sheet 3, Item V, Columns (17) and (18).
(f) See Exhibit IV, Sheet 1, Column (5).

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Estimated Increase in NICA Claim Frequency Related to Change in Coverage Trigger
from the Current Mental "and" Physical Impairment to Alternative Mental "and / or" Physical Impairment

2022 Birth Year Estimate

	Current Birth Weight Threshold 2,500 Grams & Above	Birth Weight Range 2,000 to 2,500 Grams	Current Birth Weight Threshold 2,000 Grams & Above
	(2)	(3)	(4)
1. Estimated 2022 NICA Accepted Claims - Based on Current Coverage Trigger (i.e. "and") (a)			
a. All Accepted - Includes Deceased Prior to Acceptance	20.03	8.46	28.49
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	14.56	6.15	20.72
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	5.46	2.31	7.77
2. Indicated Ratio of Mental "and/or" Physical Impairment to Mental "and" Physical Impairment			
a. Based on University of Florida Medical College Report - Score of 50 and Below (b)	1.725	2.600	
b. Based on University of Florida Medical College Report - Score of 51 to 69 (c)	5.500	12.500	
c. Based on University of Florida Medical College Report - Score of 70 and Below (d)	2.750	5.000	
d. Selected Ratio of Mental "and/or" Physical Impairment to Mental "and" Physical Impairment [(2a) X .65] + [(2c) X .35]	2.084	3.440	

	Change in Coverage Trigger Only No Change in Birth Weight	Change in Coverage Trigger on BW Range 2,000 to 2,500 Grams	Both Changes Decrease in BW and Change in Coverage Trigger to "and/or" (5) + (6)
	(5)	(6)	(7)
3. Estimated Increase in 2022 NICA Accepted Claims - Based on Alternative Coverage Trigger (i.e. "and/or")			
a. All Accepted - Includes Deceased Prior to Acceptance = (1a.) X (2d. - 1.0)	21.703	20.647	42.350
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased = (1b.) X (2d. - 1.0)	15.784	15.016	30.800
c. Accepted Claims - Deceased Prior to Acceptance = (3a.) - (3b.)	5.919	5.631	11.550

Notes: (a) See Exhibit II, Sheet 1, Items I.1 and II.1 for BW's 2,500 grams and above and BW's between 2,000 and 2,500 grams, respectively.
(b) See Exhibit IV, Sheet 1, Columns (12) and (15).
(c) See Exhibit IV, Sheet 2, Columns (12) and (15).
(d) See Exhibit IV, Sheet 3, Columns (12) and (15).

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit IV
Sheet 1

Ratio of "And" to "And/Or" Coverage Trigger

1990 University of Florida Study Data (a)

Current Assumed Impairment Level (50 or Less)

Diagnosis Type	Mental "and" Physical Impairment Impairment = Both Scores 50 and Below: Births in Excess of 2,499 Grams	Births Less Than 1,000 Grams	Births Between 1,000 and 1,500	Births Between 1,500 and 2,500	Total Births All Weights (2) + (3) + (4) +(5)	Mental "and / or" Physical Impairment Impairment = Both or Either Scores 50 and Below: Births in Excess of 2,499 Grams	Births Less Than 1,000 Grams	Births Between 1,000 and 1,500	Births Between 1,500 and 2,500	Total Births All Weights (7) + (8) + (9) +(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Resuscitated / Asphyxia	39	21	21	31	112	66	31	42	81	220
Mechanical Injury / Abruption	12	4	4	3	23	22	9	9	7	47
Totals :	51	25	25	34	135	88	40	51	88	267
All Florida Births 2019	200,718	1,763	1,706	15,823	220,010	200,718	1,763	1,706	15,823	220,010
		Percent of Births by Birth Weight Range - "and"					Percent of Births by Birth Weight Range - "and/or"			
I. Resus. / Asphyxia / M.I. / Abrupt.	37.78%	18.52%	18.52%	25.19%	100.00%	32.96%	14.98%	19.10%	32.96%	100.00%
II. All Florida Births 2019	91.23%	0.80%	0.78%	7.19%	100.00%	91.23%	0.80%	0.78%	7.19%	
III. Ratio of (I) / (II)	0.414	23.110	23.882	3.502		0.361	18.696	24.633	4.583	
IV. Incidence Rate Relative to Above 2,500 Grams (i.e. Col. (2) or (7))		55.809	57.674	8.457			51.750	68.186	12.685	
Selected Ratio Based on U of Fla. Report		55.000	55.000	8.500			50.000	65.000	12.500	

Ratio of Mental "and/or" Physical Impairment to Mental "and" Physical Impairment Cases - By Birthweight Range - Impairment Score of 50 and Below

Diagnosis Type	Births in Excess of 2,499 Grams (7) / (2)	Births Less Than 1,000 Grams (8) / (3)	Births Between 1,000 and 2,500 (9) / (4)	Births Between 1,500 and 2,500 (10) / (5)	All Weights Combined (11) / (6)
(1)	(12)	(13)	(14)	(15)	(16)
Resuscitated / Asphyxia	1.692	1.476	2.000	2.613	1.964
Mechanical Injury / Abruption	1.833	2.250	2.250	2.333	2.043
Totals :	1.725	1.600	2.040	2.588	1.978
Selected	1.725	1.600	2.000	2.600	2.000

Notes: (a) Based on University of Florida data obtained for births admitted to Regional Perinatal Intensive Care Centers over the period from 1980 to 1989. The study population contained 4,177 infants with developmental data (impairment scores). The above information is obtained from a series of reports prepared by University of Florida College of Medicine (Drs. Resnick, Ariet and Roth) in January 1991

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Ratio of "And" to "And/Or" Coverage Trigger

1990 University of Florida Study Data (a)

Increase in Impairment Level
Range from 51 to 69 Score

Diagnosis Type	Mental "and" Physical Impairment Impairment = Both Scores in the Range from 50 to 70: Births in Excess of 2,499 Grams	Births Less Than 1,000 Grams	Births Between 1,000 and 1,500	Births Between 1,500 and 2,500	Total Births All Weights (2) + (3) + (4) +(5)	Mental "and / or" Physical Impairment Impairment = Either or Both Scores in the Range from 50 to 70: Births in Excess of 2,499 Grams	Births Less Than 1,000 Grams	Births Between 1,000 and 1,500	Births Between 1,500 and 2,500	Total Births All Weights (7) + (8) + (9) +(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Resuscitated / Asphyxia	14	13	19	10	56	92	48	71	129	340
Mechanical Injury / Abruption	4	5	4	1	14	12	7	14	12	45
Totals :	18	18	23	11	70	104	55	85	141	385
All Florida Births 2019	200,718	1,763	1,706	15,823	220,010	200,718	1,763	1,706	15,823	220,010
	Percent of Births by Birth Weight Range - "and"					Percent of Births by Birth Weight Range - "and/or"				
I. Resus. / Asphyxia / M.I. / Abrupt.	25.71%	25.71%	32.86%	15.71%	100.00%	27.01%	14.29%	22.08%	36.62%	100.00%
II. All Florida Births 2019	91.23%	0.80%	0.78%	7.19%	100.00%	91.23%	0.80%	0.78%	7.19%	
III. Ratio of (I) / (II)	0.282	32.090	42.373	2.185		0.296	17.828	28.472	5.092	
IV. Incidence Rate Relative to Above 2,500 Grams (i.e. Col. (2) or (7))		113.850	150.336	7.752			60.209	96.160	17.198	
Selected Ratio Based on U of Fla. Report		120.000	150.000	7.750			60.000	90.000	17.000	

Ratio of Mental "and/or" Physical Impairment to Mental "and" Physical Impairment
Cases - By Birthweight Range - Impairment Score Between 50 and 70

Diagnosis Type	Births in Excess of 2,499 Grams (7) / (2)	Births Less Than 1,000 Grams (8) / (3)	Births Between 1,000 and 2,500 (9) / (4)	Births Between 1,500 and 2,500 (10) / (5)	All Weights Combined (11) / (6)
(1)	(12)	(13)	(14)	(15)	(16)
Resuscitated / Asphyxia	6.571	3.692	3.737	12.900	6.071
Mechanical Injury / Abruption	3.000	1.400	3.500	12.000	3.214
Totals :	5.778	3.056	3.696	12.818	5.500
Selected	5.500	3.000	3.700	12.500	5.500

Notes: (a) Based on University of Florida data obtained for births admitted to Regional Perinatal Intensive Care Centers over the period from 1980 to 1989. The study population contained 4,177 infants with developmental data (impairment scores). The above information is obtained from a series of reports prepared by University of Florida College of Medicine (Drs. Resnick, Ariet and Roth) in January 1991

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit IV
Sheet 3

Ratio of "And" to "And/Or" Coverage Trigger

1990 University of Florida Study Data (a)

Relaxation in Impairment Level
Range of 70 and Below

	Mental "and" Physical Impairment Impairment = Both Scores 70 and Below					Mental "and / or" Physical Impairment Impairment = Either/ or - Both Scores 70 and Below				
Diagnosis Type	Births in Excess of 2,499 Grams	Births Less Than 1,000 Grams	Births Between 1,000 and 1,500	Births Between 1,500 and 2,500	Total Births All Weights (2) + (3) + (4) +(5)	Births in Excess of 2,499 Grams	Births Less Than 1,000 Grams	Births Between 1,000 and 1,500	Births Between 1,500 and 2,500	Total Births All Weights (7) + (8) + (9) +(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Resuscitated / Asphyxia	53	34	40	41	168	158	79	113	210	560
Mechanical Injury / Abruption	16	9	8	4	37	34	16	23	19	92
Totals :	69	43	48	45	205	192	95	136	229	652
All Florida Births 2019	200,718	1,763	1,706	15,823	220,010	200,718	1,763	1,706	15,823	220,010
		Percent of Births by Birth Weight Range - "and"					Percent of Births by Birth Weight Range - "and/or"			
I. Resus. / Asphyxia / M.I. / Abrupt.	33.66%	20.98%	23.41%	21.95%	100.00%	29.45%	14.57%	20.86%	35.12%	100.00%
II. All Florida Births 2019	91.23%	0.80%	0.78%	7.19%	100.00%	91.23%	0.80%	0.78%	7.19%	
III. Ratio of (I) / (II)	0.369	26.176	30.196	3.052		0.323	18.183	26.900	4.884	
IV. Incidence Rate Relative to Above 2,500 Grams (i.e. Col. (2) or (7))		70.950	81.846	8.273			56.332	83.338	15.130	
Selected Ratio Based on U of Fla. Report		71.000	82.000	8.250			56.500	83.500	15.250	

Ratio of Mental "and/or" Physical Impairment to Mental "and" Physical Impairment Cases - By Birthweight Range - Scores 70 and Below

Diagnosis Type	Births in Excess of 2,499 Grams (7) / (2)	Births Less Than 1,000 Grams (8) / (3)	Births Between 1,000 and 2,500 (9) / (4)	Births Between 1,500 and 2,500 (10) / (5)	All Weights Combined (11) / (6)
(1)	(12)	(13)	(14)	(15)	(16)
Resuscitated / Asphyxia	2.981	2.324	2.825	5.122	3.333
Mechanical Injury / Abruption	2.125	1.778	2.875	4.750	2.486
Totals :	2.783	2.209	2.833	5.089	3.180
Selected	2.750	2.200	2.850	5.000	3.250

Notes: (a) Based on University of Florida data obtained for births admitted to Regional Perinatal Intensive Care Centers over the period from 1980 to 1989. The study population contained 4,177 infants with developmental data (impairment scores). The above information is obtained from a series of reports prepared by University of Florida College of Medicine (Drs. Resnick, Ariet and Roth) in January 1991

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit V
Sheet 1

Estimation of 2022 Level Average Claim Size

Birth Year	2022 Level Ultimate Loss & ALAE After Prospective Inflation & Discount (a)	Estimated Ultimate Number (b) of NICA Accepted Claims: All Accepted Including Deceased Prior to Report	Estimated Ultimate Number (b) of NICA Accepted Claims: All Accepted Excluding Deceased Prior to Report	Estimated 2022 Level Loss & ALAE Related to NICA Claimants Deceased prior to Report (c)	2022 Level Ultimate Loss & ALAE After Prospective Inflation & Discount on Claimants Alive Upon Date Reported (2) - (5)	Indicated 2022 Level Ultimate Loss & ALAE per Claimant (6) / (2)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
2000	17,460,763	13	6	1,187,384	16,273,379	2,712,230
2001	27,488,622	13	4	1,452,980	26,035,642	6,508,911
2002	66,351,735	22	17	818,920	65,532,816	3,854,872
2003	15,139,603	9	3	994,755	14,144,847	4,714,949
2004	26,947,387	13	6	1,161,490	25,785,897	4,297,650
2005	33,464,117	13	11	325,245	33,138,872	3,012,625
2006	47,617,342	13	12	180,262	47,437,080	3,953,090
2007	36,599,285	15	10	629,202	35,970,083	3,597,008
2008	49,810,701	11	10	163,211	49,647,489	4,964,749
2009	58,662,680	17	11	1,150,857	57,511,823	5,228,348
2010	30,847,864	12	6	964,069	29,883,796	4,980,633
2011	50,185,608	14	12	328,839	49,856,769	4,154,731
2012	34,444,766	11	7	642,159	33,802,606	4,828,944
2013	30,048,378	11	8	514,926	29,533,452	3,691,681
2014	36,822,269	13	10	498,395	36,323,874	3,632,387
2015	67,525,542	21	15	1,004,719	66,520,823	4,434,722
2016	24,180,964	10	6	827,078	23,353,886	3,892,314
2017	50,944,600	18	15	318,587	50,626,013	3,375,068
2018	67,364,006	28	18	1,676,984	65,687,022	3,649,279
2019	65,351,728	21	17	316,944	65,034,784	3,825,576
2020	55,135,291	18	14	335,000	54,800,291	3,914,306
Subtotals						
2016 to 2020	262,976,588		70		259,501,995	3,707,171
2010 to 2020	512,851,015		128		505,423,315	3,948,620
2005 to 2020	739,005,140		182		729,128,662	4,006,201
2000 to 2020	892,393,250		218		876,901,243	4,022,483
2010 to 2015	249,874,427		58		245,921,320	4,240,023
2005 to 2015	476,028,551		112		469,626,667	4,193,095

(8) Selected 2022 Average Claim - After Inflation / Discount - Claimants Alive Upon Report Date 3,950,000
(9) Selected 2022 Average Claim - After Inflation / Discount - Claimants Deceased Prior to Report Date 325,000

Notes: (a) See Exhibit V, Sheet 2.
(b) See Exhibit X, Sheet 1a of the NICA loss and LAE reserve report evaluated as of June 30, 2021
(c) Based on actual amounts incurred as of June 30, 2021 for claimants deceased prior to report. Future claimants deceased prior to date of report will have estimated average claim size of approximately $ 325,000.

Estimation of 2022 Level Average Claim Size

Adjustment of Prior Birth Year Estimates to 2022 Loss Level - After Inflation / Discount (a)

Birth Year	Actual Paid (b) Before Adjustment @ 6/30/21 Includes All Payments	Actual Paid (c) Before Adjustment @ 6/30/21 Excludes Retroactive & SB 1786 Payments	Paid (d) Before Adjustment Adjusted to BY Level	Inflation Adjustment Factor to 2021 Level Paid Basis (e)	2021 Level Paid Loss & ALAE Before Prospective Inflation / Discount [(4) X (5)] + [(2) - (3)]	Outstanding Loss & ALAE - as of @ 6/30/21 2021 Level **Before** Prospective Inflation & Discount (f)	Outstanding Loss & ALAE - as of @ 6/30/21 2021 Level **After** Prospective Inflation & Discount (f)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2000	7,366,072	6,476,164	5,497,561	1.340	8,259,066	16,920,490	12,797,704
2001	9,627,772	8,912,225	7,511,821	1.327	10,683,907	28,956,473	21,796,037
2002	20,869,046	18,338,425	15,103,063	1.312	22,348,440	73,335,078	55,735,799
2003	5,946,758	5,496,758	4,570,904	1.298	6,382,466	15,449,826	12,590,330
2004	6,697,646	6,097,646	5,163,095	1.282	7,221,572	31,638,313	23,183,884
2005	10,281,825	9,381,825	7,832,139	1.265	10,804,760	37,452,672	27,031,894
2006	12,003,689	10,953,689	9,135,407	1.250	12,466,269	56,201,035	41,695,228
2007	12,913,329	11,973,329	10,027,600	1.235	13,328,204	39,450,345	29,723,687
2008	8,151,387	7,361,353	6,186,832	1.223	8,355,390	63,474,880	44,933,683
2009	10,489,864	9,139,864	8,720,042	1.077	10,739,754	73,855,647	53,192,539
2010	3,869,633	3,419,633	3,306,704	1.068	3,980,303	40,504,324	27,207,261
2011	6,820,076	5,770,076	5,566,122	1.058	6,940,092	65,430,819	45,536,421
2012	4,550,584	3,800,584	3,692,620	1.049	4,623,127	45,048,465	30,577,470
2013	6,675,800	5,625,800	5,489,181	1.042	6,768,987	36,562,728	24,530,759
2014	7,529,941	6,329,941	6,190,029	1.036	7,613,264	45,486,843	30,314,946
2015	6,800,447	5,450,447	5,326,139	1.031	6,842,166	90,534,057	60,153,141
2016	1,410,403	1,070,369	1,053,551	1.026	1,421,236	33,449,286	22,275,757
2017	3,398,739	2,498,739	2,463,563	1.019	3,409,152	70,056,274	46,333,354
2018	4,728,346	3,528,346	3,489,002	1.014	4,736,592	92,406,685	60,843,254
2019	2,542,682	1,942,682	1,928,097	1.008	2,544,213	91,697,230	60,274,217
2020	22,378	22,378	22,293	1.004	22,378	79,486,297	52,426,786

	Actual Paid + Outstanding Loss & ALAE @ 6/30/21 2021 Level **Before** Prospective Inflation & Discount (6) + (7)	Actual Paid + Outstanding Loss & ALAE @ 6/30/21 2021 Level **After** Prospective Inflation & Discount (6) + (8)	Indicated Inflation / Discount Factor Before Adjustment for Maturity Level (10) / (9)	Prior Experience Adjusted to 2021 Level After Prospective Inflation & Discount (9) X Selected (12)	2022 Level Ultimate Loss & ALAE After Prospective Inflation & Discount (13) X 1.035
	(9)	(10)	(11)	(13)	(14)
	25,179,556	21,056,770	0.836	16,870,303	17,460,763
	39,640,380	32,479,944	0.819	26,559,055	27,488,622
	95,683,518	78,084,239	0.816	64,107,957	66,351,735
	21,832,292	18,972,795	0.869	14,627,635	15,139,603
	38,859,885	30,405,456	0.782	26,036,123	26,947,387
	48,257,433	37,836,654	0.784	32,332,480	33,464,117
	68,667,304	54,161,497	0.789	46,007,094	47,617,342
	52,778,549	43,051,891	0.816	35,361,628	36,599,285
	71,830,270	53,289,073	0.742	48,126,281	49,810,701
	84,595,400	63,932,293	0.756	56,678,918	58,662,680
	44,484,627	31,187,564	0.701	29,804,700	30,847,864
	72,370,911	52,476,513	0.725	48,488,510	50,185,608
	49,671,592	35,200,597	0.709	33,279,967	34,444,766
	43,331,715	31,299,746	0.722	29,032,249	30,048,378
	53,100,107	37,928,209	0.714	35,577,072	36,822,269
	97,376,223	66,995,307	0.688	65,242,069	67,525,542
	34,870,522	23,696,993	0.680	23,363,250	24,180,964
	73,465,426	49,742,507	0.677	49,221,835	50,944,600
	97,143,278	65,579,846	0.675	65,085,996	67,364,006
	94,241,442	62,818,429	0.667	63,141,766	65,351,728
	79,508,675	52,449,165	0.660	53,270,812	55,135,291
Average Inflation / Discount - Latest 3 Year ==>			0.667		
Average Inflation / Discount - Latest 5 Year ==>			0.672		
(12) Selected Average Inflation / Discount - Beginning Year Basis			0.670		

Notes: (a) Adjustment for prospective inflation and discount is based on an assumed average annual inflation rate of 3.50 percent and assumed investment rate of 5.00 % per annum.

(b) See actuarial report prepared as of June 30, 2021 for NICA loss and LAE reserves - Exhibit I, Sheet 1.

(c) See actuarial report prepared as of June 30, 2021 for NICA loss and LAE reserves - Exhibit IX, Sheet 6a-3.

(d) NICA loss and ALAE payments shown in column (3) after adjustment to each Birth Year level. Shown in Exhibit VIII, Sheet 1 of the NICA June 30, 2021 report.

(e) Estimated inflation adjustment is shown in June 30, 2021 NICA loss and LAE reserve report - Appendix E, Exhibit II, Sheet 3, Col. (3).

(f) See Exhibit I, Sheet 1, Columns (3) and (7) from the NICA loss and LAE Reserve Report - June 30, 2021.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit VI
Sheet 1

Estimated Cost Associated with Increase in Quality of Life Benefit
from Current $ 500 to $ 2,500 Per Calendar Year for Each Claimant Receiving NICA Benefits

I. Estimated Present Value Cost of Benefit Increase Applied to All Open and Unreported NICA claimants as of June 30, 2021

1. Total Life Expectancy - All NICA Open Accepted With Worksheets (a)	6,053.10
2. Estimated Mortality Development - Longitudinal vs. Cross Sectional (b)	1.235
3. Estimated Life Expectancy on All Open Accepted Claims - After Adjustment (1) x (2)	7,475.58
4. Number of Open Claims With Worksheets (a)	213
5. Indicated Average Remaining Life Expectancy - All Birth Years	35.10
6. Estimated Unreported (AAA) Claims + AAA Reported Without Worksheets	47
7. Estimated Remaining LE on Unreported Claims & Without Worksheets	1,649.54
8. Total Remaining Life Expectancy - Open + Unreported	9,125.12
9. Quality of Life Benefit per Family Per Year - Maximum - Before Inflation	2,000
a. Current NICA Benefit - $ 500	500
b. Alternative Set Forth in SB 1786 - Section 5 (8) (g) - Item # 3	2,500
10. Total Indicated O/S - Before Inflation / Discount (8) x (9)	18,250,239
a. Current NICA Benefit - $ 500 = (8) X (9a)	4,562,560
b. Alternative Set Forth in SB 1786 - Section 5 (8) (g) - Item # 3 = (8) X (9b)	22,812,798
11. Discount Factors	
a. Assuming Benefit Amount is Fixed and Discounted at 5 % (c)	0.42665
b. Assuming Benefit Amount Inflates at 3.5% and Discount of 5.0 % per Annum (c)	0.73591
12. Discounted Value of Alternative Benefit Levels	
a1. Assuming Benefit Amount is Fixed and Discounted at 5 % - Current $ 500 (10a) x (11a)	1,946,621
a2. Assuming Benefit Amount is Fixed and Discounted at 5 % - Current $ 2,500 (10b) x (11a)	9,733,105
b. Assuming Benefit Amount Inflates at 3.5% and Discount of 5.0 % per Annum (10b) x (11b)	16,788,245
13. Discounted Value of Additional Benefit	
a. Assuming Benefit Amount is Fixed (2,500) and Discounted at 5 % (12a2) - (12a1)	7,786,484
b. Assuming Benefit New Amount (2,500) Inflates at 3.5% and Discount of 5.0 % per Annum (12b) - (12a1)	14,841,624

II. Estimated Present Value Cost of Benefit Increase Applied to Expected NICA Claimants in Birth Year 2022
(Before Any change in Birth Weight or Coverage Trigger (i.e. and vs. and/or)

1. Estimated 2022 NICA Claim Frequency (d)	
a. All Accepted - Includes Deceased Prior to Acceptance	20.03
b. Accepted Claims - Alive Upon Acceptance - Excl. Deceased	14.56
c. Accepted Claims - Deceased Prior to Acceptance = (1a.) - (1b.)	5.46
2. Present Value Cost of $ 1 per Year beginning at Birth (e)	
a. Assuming a Flat Benefit without Inflation Adjustment - Assumed 5 % Investment Return	14.18
b. Assuming a Escalating Benefit with 3.5 % Inflation Adjustment - Assumed 5 % Investment Return	25.61
3. Assumed Average Lag in Claim Report - Adjustment for Lag in Benefits due to Lag in Claim Report	
a. Assuming a Flat Benefit without Inflation Adjustment - Assumed 5 % Investment Return	1.51
b. Assuming a Escalating Benefit with 3.5 % Inflation Adjustment - Assumed 5 % Investment Return	1.65
4. Discounted Value of Alternative Benefit	
a1. Assuming Benefit Amount is Fixed and Discounted at 5 % = Current $ 500 (1b) X 500 X [(2a)-(3a)]	92,248
a2. Assuming Benefit Amount is Fixed and Discounted at 5 % = Proposed $ 2,500 (1b) X 2,500 X [(2a)-(3a)]	461,240
b. Assuming Benefit Amount Inflates at 3.5% and Discount of 5.0 % per Annum - Proposed $ 2,500 = (1b) X 2,500 X [(2b)-(3b)]	872,342
5. Estimated 2022 Birth Year Present Value Cost - $ 2,000 Increase in Annual Benefit	
a. Assuming a Flat Benefit without Inflation Adjustment = (4a2) - (4a1)	368,992
b. Assuming a Escalating Benefit with 3.5 % Inflation Adjustment = (4b) - (4a1)	780,094

Notes: (a) Based on all individual NICA claimant worksheets as of June 30, 2021
(b) Based on the review of NICA mortality information and an assumed improvement in overall NICA average life expectancy of .20 years per year. Overall average mortality has improved at the rate of .30 years per year on average over the latest 100 years.
(c) See Appendix F, Exhibit IV, Sheet 2b of the NICA loss and LAE reserve report - June 30,2021.
(d) See Exhibit II, Sheet 2, Item I. 1.
(e) See Exhibit VI, Sheet 3b, Columns (7) and (6) totals.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)
Estimation of Additional Reserves Related to SB 1786 Benefit Changes
Based on Claim Detail as of June 30, 2021

Estimated Number Alive By Year - Based on Open Claims as of June 30, 2021

Inflation / Discount for Open Claims as of June 30, 2021

Fiscal Year	Expected Number Alive at End of Period (a)	Estimated Time of Payment (Years)	Discount Factors: Inflation 3.50% & Discount 5.00%	Discount Factors: Discount Only at 5.00%	Discounted Value: Inflation 3.50% & Discount 5.00% (2) x (4)	Discounted Value: Discount Only at 5.00% (2) x (5)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
7/1/2021 - 6/30/2022	257.2675	0.250	0.9964	0.9879	256.3437	254.1485
7/1/2022 - 6/30/2023	254.3146	1.000	0.9857	0.9524	250.6815	242.2043
7/1/2023 - 6/30/2024	251.1372	2.000	0.9716	0.9070	244.0131	227.7888
7/1/2024 - 6/30/2025	247.7521	3.000	0.9578	0.8638	237.2852	214.0176
7/1/2025 - 6/30/2026	244.1724	4.000	0.9441	0.8227	230.5159	200.8813
7/1/2026 - 6/30/2027	240.5301	5.000	0.9306	0.7835	223.8332	188.4616
7/1/2027 - 6/30/2028	236.8809	6.000	0.9173	0.7462	217.2883	176.7642
7/1/2028 - 6/30/2029	233.2242	7.000	0.9042	0.7107	210.8778	165.7481
7/1/2029 - 6/30/2030	229.5592	8.000	0.8913	0.6768	204.5988	155.3747
7/1/2030 - 6/30/2031	225.8850	9.000	0.8785	0.6446	198.4481	145.6075
7/1/2031 - 6/30/2032	222.2010	10.000	0.8660	0.6139	192.4228	136.4121
7/1/2032 - 6/30/2033	218.5064	11.000	0.8536	0.5847	186.5201	127.7562
7/1/2033 - 6/30/2034	214.8012	12.000	0.8414	0.5568	180.7379	119.6093
7/1/2034 - 6/30/2035	211.0854	13.000	0.8294	0.5303	175.0741	111.9431
7/1/2035 - 6/30/2036	207.3598	14.000	0.8176	0.5051	169.5272	104.7308
7/1/2036 - 6/30/2037	203.6254	15.000	0.8059	0.4810	164.0959	97.9473
7/1/2037 - 6/30/2038	199.8830	16.000	0.7944	0.4581	158.7788	91.5687
7/1/2038 - 6/30/2039	196.1331	17.000	0.7830	0.4363	153.5743	85.5722
7/1/2039 - 6/30/2040	192.3759	18.000	0.7718	0.4155	148.4806	79.9362
7/1/2040 - 6/30/2041	188.6114	19.000	0.7608	0.3957	143.4954	74.6399
7/1/2041 - 6/30/2042	184.8393	20.000	0.7499	0.3769	138.6166	69.6640
7/1/2042 - 6/30/2043	181.0593	21.000	0.7392	0.3589	133.8421	64.9898
7/1/2043 - 6/30/2044	177.2710	22.000	0.7287	0.3418	129.1697	60.6001
7/1/2044 - 6/30/2045	173.4739	23.000	0.7182	0.3256	124.5972	56.4781
7/1/2045 - 6/30/2046	169.6677	24.000	0.7080	0.3101	120.1225	52.6085
7/1/2046 - 6/30/2047	165.8515	25.000	0.6979	0.2953	115.7433	48.9764
7/1/2047 - 6/30/2048	162.0250	26.000	0.6879	0.2812	111.4575	45.5680
7/1/2048 - 6/30/2049	158.1876	27.000	0.6781	0.2678	107.2632	42.3703
7/1/2049 - 6/30/2050	154.3392	28.000	0.6684	0.2551	103.1587	39.3709
7/1/2050 - 6/30/2051	150.4800	29.000	0.6588	0.2429	99.1424	36.5586
7/1/2051 - 6/30/2052	146.6103	30.000	0.6494	0.2314	95.2129	33.9223
7/1/2052 - 6/30/2053	142.7303	31.000	0.6402	0.2204	91.3690	31.4520
7/1/2053 - 6/30/2054	138.8404	32.000	0.6310	0.2099	87.6091	29.1379
7/1/2054 - 6/30/2055	134.9410	33.000	0.6220	0.1999	83.9322	26.9710
7/1/2055 - 6/30/2056	131.0327	34.000	0.6131	0.1904	80.3370	24.9427
7/1/2056 - 6/30/2057	127.1163	35.000	0.6043	0.1813	76.8224	23.0450
7/1/2057 - 6/30/2058	123.1929	36.000	0.5957	0.1727	73.3878	21.2702
7/1/2058 - 6/30/2059	119.2639	37.000	0.5872	0.1644	70.0322	19.6112
7/1/2059 - 6/30/2060	115.3307	38.000	0.5788	0.1566	66.7551	18.0614
7/1/2060 - 6/30/2061	111.3953	39.000	0.5705	0.1491	63.5562	16.6144
7/1/2061 - 6/30/2062	107.4596	40.000	0.5624	0.1420	60.4348	15.2642
7/1/2062 - 6/30/2063	103.5260	41.000	0.5544	0.1353	57.3908	14.0052
7/1/2063 - 6/30/2064	99.5968	42.000	0.5464	0.1288	54.4239	12.8320
7/1/2064 - 6/30/2065	95.6750	43.000	0.5386	0.1227	51.5340	11.7397
7/1/2065 - 6/30/2066	91.7642	44.000	0.5309	0.1169	48.7214	10.7237
7/1/2066 - 6/30/2067	87.8681	45.000	0.5234	0.1113	45.9863	9.7794
7/1/2067 - 6/30/2068	83.9910	46.000	0.5159	0.1060	43.3292	8.9028
7/1/2068 - 6/30/2069	80.1373	47.000	0.5085	0.1009	40.7506	8.0898
7/1/2069 - 6/30/2070	76.3124	48.000	0.5012	0.0961	38.2513	7.3368
7/1/2070 - 6/30/2071	72.5222	49.000	0.4941	0.0916	35.8321	6.6404
7/1/2071 - 6/30/2072	68.7729	50.000	0.4870	0.0872	33.4942	5.9973
7/1/2072 - 6/30/2073	65.0708	51.000	0.4801	0.0831	31.2385	5.4042
7/1/2073 - 6/30/2074	61.4229	52.000	0.4732	0.0791	29.0660	4.8583
7/1/2074 - 6/30/2075	57.8362	53.000	0.4665	0.0753	26.9778	4.3568
7/1/2075 - 6/30/2076	54.3182	54.000	0.4598	0.0717	24.9748	3.8969
7/1/2076 - 6/30/2077	50.8764	55.000	0.4532	0.0683	23.0581	3.4762
7/1/2077 - 6/30/2078	47.5180	56.000	0.4467	0.0651	21.2284	3.0921
7/1/2078 - 6/30/2079	44.2506	57.000	0.4404	0.0620	19.4863	2.7424
7/1/2079 - 6/30/2080	41.0810	58.000	0.4341	0.0590	17.8321	2.4247
7/1/2080 - 6/30/2081	38.0160	59.000	0.4279	0.0562	16.2659	2.1370

Notes: (a) Based on number of claims by year and estimated life expectancy - see NICA Loss & LAE Reserve Report as of June 30, 2021 - Appendix E, Exhibit III, Sheets 3a through 3g.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)
Estimation of Additional Reserves Related to SB 1786 Benefit Changes
Based on Claim Detail as of June 30, 2021

Estimated Number Alive By Year - Based on Open Claims as of June 30, 2021

Fiscal Year	Expected Number Alive at End of Period (a)	Estimated Time of Payment (Years)	Discount Factors		Discounted Value	
			Inflation 3.50% & Discount 5.00%	Discount Only at 5.00%	Inflation 3.50% & Discount 5.00% (2) x (4)	Discount Only at 5.00% (2) x (5)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
7/1/2081 - 6/30/2082	35.0614	60.000	0.4218	0.0535	14.7874	1.8770
7/1/2082 - 6/30/2083	32.2227	61.000	0.4157	0.0510	13.3960	1.6429
7/1/2083 - 6/30/2084	29.5048	62.000	0.4098	0.0486	12.0909	1.4327
7/1/2084 - 6/30/2085	26.9117	63.000	0.4039	0.0462	10.8707	1.2446
7/1/2085 - 6/30/2086	24.4467	64.000	0.3982	0.0440	9.7339	1.0767
7/1/2086 - 6/30/2087	22.1122	65.000	0.3925	0.0419	8.6786	0.9275
7/1/2087 - 6/30/2088	19.9101	66.000	0.3869	0.0399	7.7027	0.7954
7/1/2088 - 6/30/2089	17.8410	67.000	0.3813	0.0380	6.8036	0.6788
7/1/2089 - 6/30/2090	15.9048	68.000	0.3759	0.0362	5.9786	0.5763
7/1/2090 - 6/30/2091	14.1004	69.000	0.3705	0.0345	5.2246	0.4866
7/1/2091 - 6/30/2092	12.4261	70.000	0.3652	0.0329	4.5385	0.4084
7/1/2092 - 6/30/2093	10.8801	71.000	0.3600	0.0313	3.9170	0.3406
7/1/2093 - 6/30/2094	9.4600	72.000	0.3549	0.0298	3.3571	0.2820
7/1/2094 - 6/30/2095	8.1639	73.000	0.3498	0.0284	2.8558	0.2318
7/1/2095 - 6/30/2096	6.9892	74.000	0.3448	0.0270	2.4099	0.1890
7/1/2096 - 6/30/2097	5.9318	75.000	0.3399	0.0258	2.0161	0.1528
7/1/2097 - 6/30/2098	4.9873	76.000	0.3350	0.0245	1.6709	0.1223
7/1/2098 - 6/30/2099	4.1509	77.000	0.3302	0.0234	1.3708	0.0970
7/1/2099 - 6/30/2100	3.4171	78.000	0.3255	0.0222	1.1123	0.0760
7/1/2100 - 6/30/2101	2.7800	79.000	0.3209	0.0212	0.8920	0.0589
7/1/2101 - 6/30/2102	2.2335	80.000	0.3163	0.0202	0.7064	0.0451
7/1/2102 - 6/30/2103	1.7705	81.000	0.3118	0.0192	0.5520	0.0340
7/1/2103 - 6/30/2104	1.3839	82.000	0.3073	0.0183	0.4253	0.0253
7/1/2104 - 6/30/2105	1.0659	83.000	0.3029	0.0174	0.3229	0.0186
7/1/2105 - 6/30/2106	0.8086	84.000	0.2986	0.0166	0.2414	0.0134
7/1/2106 - 6/30/2107	0.6038	85.000	0.2943	0.0158	0.1777	0.0095
7/1/2107 - 6/30/2108	0.4437	86.000	0.2901	0.0151	0.1287	0.0067
7/1/2108 - 6/30/2109	0.3209	87.000	0.2860	0.0143	0.0918	0.0046
7/1/2109 - 6/30/2110	0.2284	88.000	0.2819	0.0137	0.0644	0.0031
7/1/2110 - 6/30/2111	0.1605	89.000	0.2779	0.0130	0.0446	0.0021
7/1/2111 - 6/30/2112	0.1122	90.000	0.2739	0.0124	0.0307	0.0014
7/1/2112 - 6/30/2113	0.0783	91.000	0.2700	0.0118	0.0211	0.0009
7/1/2113 - 6/30/2114	0.0548	92.000	0.2661	0.0112	0.0146	0.0006
7/1/2114 - 6/30/2115	0.0384	93.000	0.2623	0.0107	0.0101	0.0004
7/1/2115 - 6/30/2116	0.0272	94.000	0.2586	0.0102	0.0070	0.0003
7/1/2116 - 6/30/2117	0.0194	95.000	0.2549	0.0097	0.0049	0.0002
7/1/2117 - 6/30/2118	0.0139	96.000	0.2512	0.0092	0.0035	0.0001
7/1/2118 - 6/30/2119	0.0101	97.000	0.2477	0.0088	0.0025	0.0001
7/1/2119 - 6/30/2120	0.0074	98.000	0.2441	0.0084	0.0018	0.0001
7/1/2120 - 6/30/2121	0.0055	99.000	0.2406	0.0080	0.0013	0.0000
7/1/2121 - 6/30/2122	0.0041	100.000	0.2372	0.0076	0.0010	0.0000
7/1/2122 - 6/30/2123	0.0031	101.000	0.2338	0.0072	0.0007	0.0000
7/1/2123 - 6/30/2124	0.0024	102.000	0.2305	0.0069	0.0005	0.0000
7/1/2124 - 6/30/2125	0.0018	103.000	0.2272	0.0066	0.0004	0.0000
7/1/2125 - 6/30/2126	0.0014	104.000	0.2239	0.0063	0.0003	0.0000
7/1/2126 - 6/30/2127	0.0010	105.000	0.2207	0.0060	0.0002	0.0000
7/1/2127 - 6/30/2128	0.0008	106.000	0.2176	0.0057	0.0002	0.0000
7/1/2128 - 6/30/2129	0.0006	107.000	0.2145	0.0054	0.0001	0.0000
7/1/2129 - 6/30/2130	0.0004	108.000	0.2114	0.0051	0.0001	0.0000
7/1/2130 - 6/30/2131	0.0003	109.000	0.2084	0.0049	0.0001	0.0000
7/1/2131 - 6/30/2132	0.0003	110.000	0.2054	0.0047	0.0001	0.0000
7/1/2132 - 6/30/2133	0.0002	111.000	0.2025	0.0044	0.0000	0.0000
7/1/2133 - 6/30/2134	0.0001	112.000	0.1996	0.0042	0.0000	0.0000
7/1/2134 - 6/30/2135	0.0001	113.000	0.1967	0.0040	0.0000	0.0000
7/1/2135 - 6/30/2136	0.0001	114.000	0.1939	0.0038	0.0000	0.0000
7/1/2136 - 6/30/2137	0.0000	115.000	0.1911	0.0037	0.0000	0.0000
7/1/2137 - 6/30/2138	0.0000	116.000	0.1884	0.0035	0.0000	0.0000
7/1/2138 - 6/30/2139	0.0000	117.000	0.1857	0.0033	0.0000	0.0000
7/1/2139 - 6/30/2140	0.0000	118.000	0.1831	0.0032	0.0000	0.0000
7/1/2140 - 6/30/2141	0.0000	119.000	0.1805	0.0030	0.0000	0.0000
Totals All:	9,187.58				6,761.26	3,919.89
	Indicated Average Discount				0.73591	0.42665

Notes: (a) Based on number of claims by year and estimated life expectancy - see NICA Loss & LAE Reserve Report as of June 30, 2021 - Appendix E, Exhibit III, Sheets 3a through 3g.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)
Estimation of Additional Reserves Related to SB 1786 Benefit Changes
Based on Claim Detail as of June 30, 2021

Discounted Value of Receiving $ 1 per Year for Life - With and Without Inflation Adjustment
Mortality Factors Exclude the DA claimants - those deceased during the first year.

Time After Birth (Years)	Probability of Death (a) By End	Probability of Survival to the end of year (b)	Estimated Time of Payment (Years)	Discount Factors: Inflation 3.50% & Discount 5.00%	Discount Factors: Discount Only at 5.00%	Mortality and Interest Discounted Value: Inflation 3.50% & Discount 5.00% (3) x (5)	Mortality and Interest Discounted Value: Discount Only at 5.00% (3) x (6)
(1)	(2)	(3)	(4)	(5)	(6)	(6)	(7)
1	0.0431	0.9785	0.5000	0.9928	0.9759	0.9715	0.9549
2	0.0315	0.9419	1.5000	0.9786	0.9294	0.9218	0.8754
3	0.0171	0.9189	2.5000	0.9647	0.8852	0.8864	0.8134
4	0.0169	0.9033	3.5000	0.9509	0.8430	0.8589	0.7615
5	0.0169	0.8880	4.5000	0.9373	0.8029	0.8323	0.7130
6	0.0169	0.8730	5.5000	0.9239	0.7646	0.8066	0.6675
7	0.0169	0.8583	6.5000	0.9107	0.7282	0.7816	0.6250
8	0.0169	0.8438	7.5000	0.8977	0.6936	0.7575	0.5852
9	0.0168	0.8296	8.5000	0.8849	0.6605	0.7341	0.5480
10	0.0168	0.8156	9.5000	0.8722	0.6291	0.7114	0.5131
11	0.0168	0.8019	10.5000	0.8598	0.5991	0.6894	0.4804
12	0.0169	0.7884	11.5000	0.8475	0.5706	0.6681	0.4498
13	0.0170	0.7750	12.5000	0.8354	0.5434	0.6474	0.4211
14	0.0172	0.7617	13.5000	0.8235	0.5175	0.6272	0.3942
15	0.0174	0.7485	14.5000	0.8117	0.4929	0.6076	0.3689
16	0.0176	0.7354	15.5000	0.8001	0.4694	0.5884	0.3452
17	0.0177	0.7224	16.5000	0.7887	0.4471	0.5697	0.3230
18	0.0179	0.7095	17.5000	0.7774	0.4258	0.5516	0.3021
19	0.0180	0.6968	18.5000	0.7663	0.4055	0.5340	0.2826
20	0.0181	0.6843	19.5000	0.7553	0.3862	0.5169	0.2643
21	0.0189	0.6716	20.5000	0.7446	0.3678	0.5001	0.2470
22	0.0191	0.6589	21.5000	0.7339	0.3503	0.4835	0.2308
23	0.0192	0.6463	22.5000	0.7234	0.3336	0.4675	0.2156
24	0.0193	0.6338	23.5000	0.7131	0.3177	0.4520	0.2014
25	0.0194	0.6216	24.5000	0.7029	0.3026	0.4369	0.1881
26	0.0195	0.6095	25.5000	0.6929	0.2882	0.4223	0.1757
27	0.0196	0.5976	26.5000	0.6830	0.2745	0.4082	0.1640
28	0.0198	0.5859	27.5000	0.6732	0.2614	0.3944	0.1531
29	0.0200	0.5742	28.5000	0.6636	0.2489	0.3811	0.1429
30	0.0202	0.5627	29.5000	0.6541	0.2371	0.3681	0.1334
31	0.0204	0.5513	30.5000	0.6448	0.2258	0.3555	0.1245
32	0.0206	0.5400	31.5000	0.6356	0.2150	0.3432	0.1161
33	0.0208	0.5288	32.5000	0.6265	0.2048	0.3313	0.1083
34	0.0210	0.5178	33.5000	0.6175	0.1951	0.3197	0.1010
35	0.0213	0.5068	34.5000	0.6087	0.1858	0.3085	0.0942
36	0.0215	0.4960	35.5000	0.6000	0.1769	0.2976	0.0878
37	0.0218	0.4853	36.5000	0.5914	0.1685	0.2870	0.0818
38	0.0220	0.4746	37.5000	0.5830	0.1605	0.2767	0.0762
39	0.0223	0.4641	38.5000	0.5747	0.1528	0.2667	0.0709
40	0.0226	0.4537	39.5000	0.5665	0.1456	0.2570	0.0660
41	0.0260	0.4427	40.5000	0.5584	0.1386	0.2472	0.0614
42	0.0265	0.4310	41.5000	0.5504	0.1320	0.2372	0.0569
43	0.0270	0.4195	42.5000	0.5425	0.1257	0.2276	0.0527
44	0.0276	0.4081	43.5000	0.5348	0.1197	0.2182	0.0489
45	0.0282	0.3967	44.5000	0.5271	0.1140	0.2091	0.0452
46	0.0289	0.3853	45.5000	0.5196	0.1086	0.2002	0.0419
47	0.0297	0.3741	46.5000	0.5122	0.1034	0.1916	0.0387
48	0.0305	0.3628	47.5000	0.5049	0.0985	0.1832	0.0357
49	0.0313	0.3516	48.5000	0.4977	0.0938	0.1750	0.0330
50	0.0323	0.3404	49.5000	0.4905	0.0894	0.1670	0.0304
51	0.0333	0.3293	50.5000	0.4835	0.0851	0.1592	0.0280
52	0.0343	0.3182	51.5000	0.4766	0.0810	0.1516	0.0258
53	0.0354	0.3071	52.5000	0.4698	0.0772	0.1443	0.0237
54	0.0366	0.2960	53.5000	0.4631	0.0735	0.1371	0.0218
55	0.0379	0.2850	54.5000	0.4565	0.0700	0.1301	0.0200
56	0.0393	0.2740	55.5000	0.4500	0.0667	0.1233	0.0183
57	0.0407	0.2630	56.5000	0.4435	0.0635	0.1167	0.0167
58	0.0423	0.2521	57.5000	0.4372	0.0605	0.1102	0.0152
59	0.0439	0.2413	58.5000	0.4310	0.0576	0.1040	0.0139
60	0.0456	0.2305	59.5000	0.4248	0.0549	0.0979	0.0126

Notes: (a) Based upon the review of standard mortality adjusted to NICA experience levels. The mortality factors are further adjusted to include consideration of likely improvements in mortality over time.
(b) Probability based on mortality decrements in column (2) adjusted to include consideration of 1/2 year of benefit for those deceased during the most recent year.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)
Estimation of Additional Reserves Related to SB 1786 Benefit Changes
Based on Claim Detail as of June 30, 2021

Discounted Value of Receiving $ 1 per Year for Life - With and Without Inflation Adjustment
Mortality Factors Exclude the DA claimants - those deceased during the first year.

Time After Birth (Years)	Probability of Death (a) By End	Probability of Survival to the end of year (b)	Estimated Time of Payment (Years)	Discount Factors		Discounted Value	
				Inflation 3.50% & Discount 5.00%	Discount Only at 5.00%	Inflation 3.50% & Discount 5.00% (3) x (5)	Discount Only at 5.00% (3) x (6)
(1)	(2)	(3)	(4)	(5)	(6)	(6)	(7)
61	0.0877	0.2152	60.5000	0.4187	0.0522	0.0901	0.0112
62	0.0923	0.1959	61.5000	0.4128	0.0498	0.0808	0.0097
63	0.0974	0.1773	62.5000	0.4069	0.0474	0.0721	0.0084
64	0.1029	0.1596	63.5000	0.4010	0.0451	0.0640	0.0072
65	0.1089	0.1427	64.5000	0.3953	0.0430	0.0564	0.0061
66	0.1152	0.1267	65.5000	0.3897	0.0409	0.0494	0.0052
67	0.1219	0.1117	66.5000	0.3841	0.0390	0.0429	0.0044
68	0.1289	0.0978	67.5000	0.3786	0.0371	0.0370	0.0036
69	0.1362	0.0848	68.5000	0.3732	0.0354	0.0317	0.0030
70	0.1442	0.0730	69.5000	0.3679	0.0337	0.0268	0.0025
71	0.1530	0.0621	70.5000	0.3626	0.0321	0.0225	0.0020
72	0.1625	0.0524	71.5000	0.3574	0.0305	0.0187	0.0016
73	0.1730	0.0436	72.5000	0.3523	0.0291	0.0154	0.0013
74	0.1844	0.0358	73.5000	0.3473	0.0277	0.0124	0.0010
75	0.1967	0.0290	74.5000	0.3423	0.0264	0.0099	0.0008
76	0.2100	0.0231	75.5000	0.3374	0.0251	0.0078	0.0006
77	0.2242	0.0181	76.5000	0.3326	0.0239	0.0060	0.0004
78	0.2394	0.0140	77.5000	0.3279	0.0228	0.0046	0.0003
79	0.2557	0.0105	78.5000	0.3232	0.0217	0.0034	0.0002
80	0.2734	0.0077	79.5000	0.3186	0.0207	0.0025	0.0002
81	0.2926	0.0056	80.5000	0.3140	0.0197	0.0017	0.0001
82	0.3132	0.0039	81.5000	0.3095	0.0188	0.0012	0.0001
83	0.3354	0.0026	82.5000	0.3051	0.0179	0.0008	0.0000
84	0.3594	0.0017	83.5000	0.3008	0.0170	0.0005	0.0000
85	0.3852	0.0011	84.5000	0.2965	0.0162	0.0003	0.0000
86	0.4130	0.0007	85.5000	0.2922	0.0154	0.0002	0.0000
87	0.4428	0.0004	86.5000	0.2880	0.0147	0.0001	0.0000
88	0.4749	0.0002	87.5000	0.2839	0.0140	0.0001	0.0000
89	0.5093	0.0001	88.5000	0.2799	0.0133	0.0000	0.0000
90	0.5461	0.0001	89.5000	0.2759	0.0127	0.0000	0.0000
91	0.5854	0.0000	90.5000	0.2719	0.0121	0.0000	0.0000
92	0.6273	0.0000	91.5000	0.2681	0.0115	0.0000	0.0000
93	0.6719	0.0000	92.5000	0.2642	0.0110	0.0000	0.0000
94	0.7190	0.0000	93.5000	0.2604	0.0104	0.0000	0.0000
95	0.7681	0.0000	94.5000	0.2567	0.0099	0.0000	0.0000
96	0.8192	0.0000	95.5000	0.2531	0.0095	0.0000	0.0000
97	0.8721	0.0000	96.5000	0.2494	0.0090	0.0000	0.0000
98	0.9272	0.0000	97.5000	0.2459	0.0086	0.0000	0.0000
99	0.9849	0.0000	98.5000	0.2424	0.0082	0.0000	0.0000
100	1.0000	0.0000	99.5000	0.2389	0.0078	0.0000	0.0000
101	1.0000	0.0000	100.5000	0.2355	0.0074	0.0000	0.0000
102	1.0000	0.0000	101.5000	0.2321	0.0071	0.0000	0.0000
103	1.0000	0.0000	102.5000	0.2288	0.0067	0.0000	0.0000
104	1.0000	0.0000	103.5000	0.2255	0.0064	0.0000	0.0000
105	1.0000	0.0000	104.5000	0.2223	0.0061	0.0000	0.0000
106	1.0000	0.0000	105.5000	0.2191	0.0058	0.0000	0.0000
107	1.0000	0.0000	106.5000	0.2160	0.0055	0.0000	0.0000
108	1.0000	0.0000	107.5000	0.2129	0.0053	0.0000	0.0000
109	1.0000	0.0000	108.5000	0.2099	0.0050	0.0000	0.0000
110	1.0000	0.0000	109.5000	0.2069	0.0048	0.0000	0.0000
111	1.0000	0.0000	110.5000	0.2039	0.0046	0.0000	0.0000
112	1.0000	0.0000	111.5000	0.2010	0.0043	0.0000	0.0000
113	1.0000	0.0000	112.5000	0.1981	0.0041	0.0000	0.0000
114	1.0000	0.0000	113.5000	0.1953	0.0039	0.0000	0.0000
115	1.0000	0.0000	114.5000	0.1925	0.0037	0.0000	0.0000
116	1.0000	0.0000	115.5000	0.1898	0.0036	0.0000	0.0000
117	1.0000	0.0000	116.5000	0.1871	0.0034	0.0000	0.0000
118	1.0000	0.0000	117.5000	0.1844	0.0032	0.0000	0.0000
119	1.0000	0.0000	118.5000	0.1818	0.0031	0.0000	0.0000
120	1.0000	0.0000	119.5000	0.1792	0.0029	0.0000	0.0000
						25.6100	14.1782

Notes: (a) Based upon the review of standard mortality adjusted to NICA experience levels. The mortality factors are further adjusted to include consideration of likely improvements in mortality over time.
(b) Probability based on mortality decrements in column (2) adjusted to include consideration of 1/2 year of benefit for those deceased during the most recent year.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Estimated Percent of Cerebral Palsy Cases Resulting in NICA Claims
Based on Birthweights 2,500 Grams and Greater

Year	# of Florida Births (a) All Weights	Births (a) Above 2,500 Grams	Births (a) 2,000 to 2,500 Grams	Births (a) 1,500 to 2,500 Grams	NICA Accepted Claims All (b)	NICA Accepted Claims Alive When (b) Accepted	Estimated Births Above 2,500 Grams Covered By NICA (3) X .90
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
2009	221,391	202,094	12,131	15,753	17	11	181,885
2010	214,519	195,800	11,690	15,197	12	6	176,220
2011	213,237	194,679	11,517	15,125	14	12	175,211
2012	212,954	194,663	11,344	14,876	11	7	175,197
2013	215,194	196,823	11,526	15,060	11	8	177,141
2014	219,905	200,801	11,786	15,554	13	10	180,721
2015	224,273	204,906	12,021	15,870	21	15	184,415
2016	225,018	205,357	12,348	16,183	10	6	184,821
2017	223,579	203,880	12,361	16,214	18	15	183,492
2018	221,508	202,237	12,112	15,734	28	18	182,013
2019	220,010	200,718	12,159	15,823	21	17	180,646
2009 to 2019	2,411,588	2,201,958	130,995	171,389	176	125	1,981,762
2009 to 2014	1,297,200	1,184,860	69,994	91,565	78	54	1,066,374
2015 to 2019	1,114,388	1,017,098	61,001	79,824	98	71	915,388
2016 to 2019	890,115	812,192	48,980	63,954	77	56	730,973
2017 to 2019	665,097	606,835	36,632	47,771	67	50	546,152

	Related to Births Above 2,500		NICA Claim Frquency per 1,000 Births 2,500 grams and above		Based on Births above Above 2,500 Grams			
	Estimated Cerebral Palsy Births Quadriplegias Only (c) Incl. Congenital Anomalies	Estimated Cerebral Palsy Births All Types (c) Incl. Congenital Anomalies	All Accepted NICA Claims	Accepted when Alive NICA Claims	Ratio of NICA Accepted Claims to Estimated Cerebral Palsy Claims - Quadriplegias Only		Ratio of NICA Accepted Claims to Estimated Cerebral Palsy Claims - All Types	
Year	[(8) / 1,000] X 0.40	[(8) / 1,000] X 1.10	(6) / [(8) / 1,000]	(7) / [(8) / 1,000]	All NICA Accepted (6) / (9)	Accepted Claims Alive (7) / (9)	All NICA Accepted (6) / (10)	Accepted Claims Alive (7) / (10)
(1)	(9)	(10)	(11)	(12)	(13)	(14)	(14)	(15)
2009	73	200	0.093	0.060	0.234	0.151	0.085	0.055
2010	70	194	0.068	0.034	0.170	0.085	0.062	0.031
2011	70	193	0.080	0.068	0.200	0.171	0.073	0.062
2012	70	193	0.063	0.040	0.157	0.100	0.057	0.036
2013	71	195	0.062	0.045	0.155	0.113	0.056	0.041
2014	72	199	0.072	0.055	0.180	0.138	0.065	0.050
2015	74	203	0.114	0.081	0.285	0.203	0.104	0.074
2016	74	203	0.054	0.032	0.135	0.081	0.049	0.030
2017	73	202	0.098	0.082	0.245	0.204	0.089	0.074
2018	73	200	0.154	0.099	0.385	0.247	0.140	0.090
2019	72	199	0.116	0.094	0.291	0.235	0.106	0.086
2009 to 2019	793	2,180	0.089	0.063	0.222	0.158	0.081	0.057
2009 to 2014	427	1,173	0.073	0.051	0.183	0.127	0.066	0.046
2015 to 2019	366	1,007	0.107	0.078	0.268	0.194	0.097	0.071
2016 to 2019	292	804	0.105	0.077	0.263	0.192	0.096	0.070
2017 to 2019	218	601	0.123	0.092	0.307	0.229	0.112	0.083
(15) Selected			0.110	0.080	0.270	0.195	0.100	0.072

Notes: (a) Obtained from Florida Vital Statistics Annual Report - 2009 to 2019.
(b) Based on estimates shown in the NICA Loss and LAE Reserve Report - June 30, 2021 - Exhibit X, Sheet 1a.
(c) Selected based on University of Liverpool study - see Exhibit IX, Items (21) and (22).

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit VII
Sheet 2

Summary of Births by Weight - Florida

Year	Births by Weight (grams) Less Than 500	500 to 999	1,000 to 1,499	1,500 to 1,999	2,000 to 2,499	2,500 to 2,999	3,000 to 3,499	3,500 to 3,999	Above 4,000	Unknown	# of Florida Births (a)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
2009	425	1,377	1,742	3,622	12,131	43,282	89,654	54,963	14,177	18	221,391
2010	418	1,346	1,758	3,507	11,690	42,129	85,806	53,968	13,841	56	214,519
2011	411	1,389	1,633	3,608	11,517	41,624	85,420	53,531	14,065	39	213,237
2012	375	1,310	1,730	3,532	11,344	40,880	85,049	54,085	14,617	32	212,954
2013	380	1,291	1,640	3,534	11,526	41,198	85,482	55,220	14,903	20	215,194
2014	398	1,356	1,796	3,768	11,786	41,797	86,874	56,479	15,625	26	219,905
2015	474	1,306	1,717	3,849	12,021	42,995	88,498	57,414	15,950	49	224,273
2016	449	1,320	1,709	3,835	12,348	43,507	88,787	57,284	15,764	15	225,018
2017	412	1,265	1,808	3,853	12,361	44,122	88,429	56,098	15,216	15	223,579
2018	380	1,320	1,837	3,622	12,112	43,049	87,218	56,473	15,479	18	221,508
2019	426	1,337	1,706	3,664	12,159	43,079	87,334	55,352	14,934	19	220,010
2017 to 2019	1,218	3,922	5,351	11,139	36,632	130,250	262,981	167,923	45,629	52	665,097
(18 A) Estimated 2022 Births											221,699

Year	Births 2000 to 2,499 Grams Col. (6)	Above 2,499 Sum of (7) to (11)	Ratio of 2,000 to 2,499 to Above 2,499 (6)/(14)	Ratio of 2,000 to 2,499 to 1,500 to 2,499 (6) / [(5)+(6)]	% Below 2,500 Grams Sum of (2) to (6) / (12)
(1)	(13)	(14)	(15)	(16)	(17)
2009	12,131	202,094	0.0600	0.7701	0.0872
2010	11,690	195,800	0.0597	0.7692	0.0873
2011	11,517	194,679	0.0592	0.7615	0.0870
2012	11,344	194,663	0.0583	0.7626	0.0859
2013	11,526	196,823	0.0586	0.7653	0.0854
2014	11,786	200,801	0.0587	0.7577	0.0869
2015	12,021	204,906	0.0587	0.7575	0.0864
2016	12,348	205,357	0.0601	0.7630	0.0874
2017	12,361	203,880	0.0606	0.7624	0.0881
2018	12,112	202,237	0.0599	0.7698	0.0870
2019	12,159	200,718	0.0606	0.7684	0.0877
2017 to 2019	36,632	606,835	0.0604	0.7668	0.0876
(18 B) Estimated 2022 Births	12,211	202,278			

Notes: (a) Obtained from Florida Vital Statistics Annual Report - 2009 to 2019.

Prevalence of Cerebral Palsy By Birth Weight (a)
Based on Atlanta Birth Study - 1985 to 2002

Birth Weight Range	Cerebral Palsy per 1,000 Births								
	1985	1986	1988	1992	1994	1996	1998	2000	2002
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
I. Less Than 1,500 gr.	65.63	65.71	37.74	44.40	66.40	54.80	66.40	53.70	40.80
II. 1,500 to 2,499 gr.	8.16	7.09	3.10	7.10	5.50	4.10	4.40	3.30	6.20
III. 2,500 gr. And Above	0.74	0.91	0.72	0.60	0.80	1.00	0.70	0.90	0.80
IV. All Weights Combined	1.87	1.99	1.25	1.60	1.90	1.90	2.00	1.80	1.70

Birth Weight Range	CP Incidence Per 1,000 Births							
	Standard Deviation	Simple Average	Low Value	High Value	Avg. - 1 Std. Dev.	Avg. + 1 Std. Dev.	Selected Low	Selected High
(1)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
I. Less Than 1,500 gr.	11.73	55.06	37.74	66.40	43.33	66.80	43.50	55.00
II. 1,500 to 2,499 gr.	1.82	5.44	3.10	8.16	3.62	7.26	4.00	7.50
III. 2,500 gr. And Above	0.12	0.80	0.60	1.00	0.67	0.92	0.65	0.95
IV. All Weights Combined	0.24	1.78	1.25	2.00	1.54	2.02	1.50	2.00
V. Ratio of II. To III.		6.83	5.17	8.16	5.38	7.88	6.15	7.89

Notes: (a) Based on a study of children born in metropolitan Atlanta over the period from 1985 to 2002.
Obtained from article by Braun, Doemberg, Schieve, Christiansen, Goodman and Yeargin-Allsop - see
"Birth Prevalence of Cerebral Palsy: A Population Based Study" Pediatrics 2016 - January

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit VII
Sheet 4

Summary of Birth Weight Distributions - Countrywide Versus Florida

	Percent of Births Below 2,500 grams		
	1998 to 2000	2001 to 2003	2001 to 2003
1. United States	0.0759	0.0781	0.0818
2. Florida Only	0.0806	0.0836	0.0867
3. Ratio of Florida to Countrywide Avg.	1.062	1.070	1.060

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Summary of Births by Weight - Countrywide

Birthweight	United States All Births 2012 (a)	Pre - Term (a) - 2012 Under 28 Weeks	28 - 31 Weeks	32 - 34 Weeks	34 - 36 Weeks	2012 Term (a) 37 - 41 Weeks	2012 Post-Term 42 (a) Weeks and Over	2006 Fetal Mortality Rate per 1,000 Births	Estimated CP Rate per 1,000 Births Low (b)	Estimated CP Rate per 1,000 Births High (b)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
All Births	3,952,841	29,013	47,028	58,673	321,204	3,271,092	225,831	6.05	1.50	2.00
Less than 500 gr.	5,947	5,665	204	12	14	16	36	529.49		
500 to 999 gr.	21,432	15,897	4,850	314	140	163	68	171.72		
1,000 to 1,499 gr.	28,873	3,843	15,603	4,768	2,828	1,558	273	62.80		
1,500 to 1,999 gr.	61,499	748	11,273	18,009	21,618	8,944	907	28.68		
2,000 to 2,499 gr.	197,958	669	3,811	16,025	80,479	91,909	5,065	8.34		
2,500 to 2,999 gr.	721,840	1,176	3,991	8,027	107,600	569,820	31,226	2.21		
3,000 to 3,499 gr.	1,540,161		4,664	7,189	73,832	1,365,338	89,138	0.82		
3,500 to 3,999 gr.	1,058,604		2,460	3,505	27,511	951,949	73,179	0.64		
4,000 to 4,499 gr.	269,581			567	5,786	241,910	21,318	1.29		
4,500 to 4,999 gr.	38,288			99	938	33,823	3,428	1.29		
5,000 gr. or More	4,650			21	199	4,019	411	1.29		
No BW Info.	4,008	1,015	172	137	259	1,643	782			
Subtotals: All Categories	3,952,841	29,013	47,028	58,673	321,204	3,271,092	225,831			
2,500 gr. Or More	3,637,132	2,191	11,287	19,545	216,125	3,168,502	219,482			
2,000 to 2,499 gr.	197,958	669	3,811	16,025	80,479	91,909	5,065			
1,999 gr.or Less	117,751	26,153	31,930	23,103	24,600	10,681	1,284			
Less Than 1,500 gr.	56,252	25,405	20,657	5,094	2,982	1,737	377		43.50	55.00
1,500 to 2,499 gr.	259,457	1,417	15,084	34,034	102,097	100,853	5,972		4.00	7.50
2,500 gr. And Above	3,637,132	2,191	11,287	19,545	216,125	3,168,502	219,482		0.65	0.95
% of Births Below 2,500 Grams	7.99%									
Ratio of 2,000 to 2,499 to 2,500 gr. And Above	5.44%	30.53%	33.76%	81.99%	37.24%	2.90%	2.31%			
Ratio of 2,000 to 2,499 to 1,500 to 2,499 gr.	76.30%	47.21%	25.27%	47.09%	78.83%	91.13%	84.81%			

Notes: (a) Based on information from National Vital Statistics Reports, Vol. 62,No. 9, December 30, 2013
(b) All Birth Weights CP rate is based on a variety of sources. The CP rate by Birth Weight range is selected based on data shown in Exhibit VII, Sheet 3.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit VIII

Ratio of Florida Participating Physicians to Estimated Florida OB/GYN's Performing Deliveries

Year	NICA (a) Participating Physicians	Florida Physicians All (b) Specialties	Florida (b) Physicians OB/GYN's	Estimated % of (b) OB/GYN's Performing Deliveries Based on Survey	Estimate of Number of OB/GYN's Performing Deliveries	Indicated Percent of OB/GYN's Performing Deliveries Covered By NICA
(1)	(2)	(3)	(4)	(5)	(6)	(7)
2005	891					
2006	897					
2007	963					
2008	987					
2009	1,044					
2010	1,071			73.90%		
2011	1,091			70.60%		
2012	1,119			71.40%		
2013	1,143	43,406	1,851	68.80%	1,296	88.21%
2014	1,208	43,957	N/A	N/A		
2015	1,273	44,685	N/A	N/A		
2016	1,318	45,746	N/A	N/A		
2017	1,356	45,995	1,815	63.00%	1,271	106.73%
2018	1,420	50,561	N/A	N/A		
2019	1,501	51,370	N/A	N/A		
2020	1,575	53,002	2,396	N/A	1,677	93.91%
2021	1,543					
Total of 2013, 2017 & 2020	4,074		6,062		4,243	96.01%
		(8) Selected Percent Covered By NICA				90.00%

Notes: (a) Provided by NICA.
(b) From 2013, 2017 and 2020 Florida Physician Workforce Annual Reports.

Florida Birth Related Neurological Injury Compensation Association
Review of Claim Definition Changes Described in SB 1786 Section 5 (8g)

Exhibit IX

Summary of Cerebral Palsy Births by Weight - United Kingdom (a)

Time Period	Birth Weight Range (Grams)	Number of Live Births	Number of Neonatal Survivors	All Cerebral Palsy Types	Segregated by Type: Paralysis of One - Side Hemiplegias	Paralysis of Both Arms or Both Legs Diplegias	Paralysis of Both Arms and Both Legs Quadriplegias	Other
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1967 - 1975	< 1500	2,720	1,093	33	5	18	10	0
	1501 - 2500	21,972	20,686	118	27	46	37	8
	> 2500	324,627	319,649	381	120	56	153	52
	Total	349,319	341,428	532	152	120	200	60
1976 - 1984	< 1500	2,035	1,266	88	26	38	22	2
	1501 - 2500	15,143	14,792	145	43	50	47	5
	> 2500	262,043	261,144	268	110	26	98	34
	Total	279,221	277,202	501	179	114	167	41

		Rate per 1,000 Live Births Segregated by Type: All Types	Hemiplegias	Diplegias	Quadriplegias	Other
		(10)	(11)	(12)	(13)	(14)
1967 - 1975	< 1500	12.13	1.84	6.62	3.68	0.00
	1501 - 2500	5.37	1.23	2.09	1.68	0.36
	> 2500	1.17	0.37	0.17	0.47	0.16
	Total	1.52	0.44	0.34	0.57	0.17
1976 - 1984	< 1500	43.24	12.78	18.67	10.81	0.98
	1501 - 2500	9.58	2.84	3.30	3.10	0.33
	> 2500	1.02	0.42	0.10	0.37	0.13
	Total	1.79	0.64	0.41	0.60	0.15

		Ratio of Rate per 1,000 to Rate per 1,000 for B W above 2,500 Grams: All Types	Hemiplegias	Diplegias	Quadriplegias	Other
		(15)	(16)	(17)	(18)	(19)
1967 - 1975	< 1500	10.34	4.97	38.36	7.80	0.00
	1501 - 2500	4.58	3.32	12.14	3.57	2.27
	> 2500	1.00	1.00	1.00	1.00	1.00
	Total	1.30	1.18	1.99	1.21	1.07
1976 - 1984	< 1500	42.28	30.44	188.20	28.91	7.57
	1501 - 2500	9.36	6.76	33.28	8.30	2.54
	> 2500	1.00	1.00	1.00	1.00	1.00
	Total	1.75	1.53	4.11	1.60	1.13

(20) Selected Cerebral Palsy Cases per 1,000 Births - All Types - Related to Births Above 2,500 Grams	1.10
(21) Selected Cerebral Palsy Cases per 1,000 Births - Quadraplegias Only - Above 2,500 Grams	0.40
(22) Selected Relativity - Rate per 1,000 Birth - All Types - 1,500 to 2,500 Rel. to > 2,500	9.00
(23) Selected Relativity - Rate per 1,000 Birth - Quadraplegias Only - 1,500 to 2,500 Rel. to > 2,500	8.00

Notes: (a) Based on a report prepared by the Department of Public Health, University of Liverpool. The data is a register of infants with cerebral palsy born over the period from 1967 to 1984

APPENDIX B

Analysis Payment Time for Fiscal Year Ending 2021 by Madison Consulting Group in October, 2021.

MADISON CONSULTING GROUP
Actuaries • Property/Casualty Consulting Services

October 21, 2021

NICA
Tim Daughtry, Deputy Director
PO Box 14567
Tallahassee, FL 32317

Re: Analysis Payment Time for Fiscal Year Ending 2021

Dear Mr. Daughtry:

The Florida Neurological Injury Association (NICA) asked Madison Consulting Group (MCG) to assist in designing a random sampling approach to measure the average time for paying claims for fiscal year ending 2021. This report describes that sampling and its results.

INTRODUCTION

SB1786 requires NICA to prepare a report to senior officials in the State on or before November 1, 2021 and annually thereafter. This report is to include the average time for paying or denying claims.

I understand NICA is in the process of enhancing its data systems to automatically capture the required information, however no such data was captured in the past. As a result, the determination of average time for paying claims for fiscal year 2021 requires time intensive review of the circumstances of each transaction across several data and filing systems.

RESULTS

The sampling analysis indicated an average time to pay claim transactions of 2.5 business days with a range of sampling error of ±0.8 business days.

The sampling analysis generally indicates quick turnaround time (i.e., an average of three workdays or less) for most types of transaction. The exceptions to this are large dollar transactions

associated with the purchase of equipment, vehicles, or housing modifications. These transactions are often complex and inherently involve delays to complete (e.g., customization of vehicles and equipment takes time, construction of a home has to be advanced before ramps can be installed etc.).

The results are based on a random sample of 405 transactions from a total of 13,871 transactions for fiscal year ending 2021.

AUTHOR

This report was prepared by Mark Crawshaw, Ph.D., FCAS, MAAA. I am a member of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

METHODOLGY

The sampling proceeded as follows:

1. NICA provided MCG with a list of all payment transactions for FYE 2021. This contained 13,434 records. NICA also provided a second list of 1,769 miscellaneous transactions. This latter file included payments for death benefits. In addition, it included ongoing payments for health insurance and other miscellaneous periodic payments mostly to insurance companies and other third-party vendors. The second set of transactions are inherently simpler for NICA to process as they generally involve either a definite benefit award or else a recurring payment. This second set was sampled separately using the approach described in (17) below. Items (2) through (16) describe the sampling for the first set of transactions.

2. MCG removed from consideration all transactions for parental awards made in June 2021. Almost all of these are retrospective payments resulting from SB 1786 and involved NICA seeking out beneficiaries rather than responding to a demand for payment.

3. MCG removed from consideration records related to payments to NICA's doctors for medical examinations to determine compensability. These transactions do not represent claim payments.

4. MCG removed all transactions for federal express bills as they are not payments to claimants.

5. MCG removed all transactions involving payments to NICA (i.e., transactions less than $0).

6. After the adjustments above, we were left with 12,865 transactions from the first set of transactions with an aggregate amount of $22,245,207.

7. MCG assigned a random number between 0 and 1 to each transaction using the random number generator in Excel. Once determined, these numbers were fixed for each transaction.

8. MCG discussed with NICA the complexity of issues in processing payments based on their dollar amount and the category they pertain to. Based on this, MCG decided to stratify the data according to inherent complexity (A = simplest; C = most complex) and amount of the transaction:

	Amount of The Transaction	
Size Group	**From**	**To**
1	$0	$500
2	500	1,000
3	1,000	2,500
4	2,500	5,000
5	5,000	100,000
6	100,000	250,000

9. The scheme above resulted in 11 strata (i.e., A1…A6, C1….C5 – there were no transactions in C6).

10. MCG ordered the transactions in each stratum based on the random number in (7) and labeled them as A1-1, A1-2..., A2-1…etc.

11. MCG instructed NICA to take an initial sample and record data for the first ten records in each stratum suitable to determine the time to pay the transaction. NICA also recorded the time taken to gather the required information.

12. NICA and MCG discussed the initial sample and the meaning of the dates recorded. MCG then expanded the sample size based on the variability expected in the data, the variability observed in the initial sample, and the time involved in researching the issues for each stratum. The expanded sample was designed to (a) examine all transactions in size groups 5 and 6, (b) provide a reliable estimate of average payment time, (c) be efficient and minimize time and resource required to conduct the study. With the expansion a total of 389 records were sampled from the test file of transactions.

13. NICA completed the expanded sample.

14. MCG analyzed the results and identified about 20 outliers for further research by NICA.

15. In some cases, the further research in (14) resulted in modification to the initial indication, in others it did not. In these later cases the payment times appeared to be the result of complex situations often involving multiple parties.

16. The second set of transactions was analyzed in a similar way. Transactions not associated with delays in claim payments were removed from consideration. Transactions so removed included payments to Federal express (609 transactions), transactions for less than $0 (148 transactions) and retroactive death benefits paid based on SB1786. After this there remained 6 transactions related to death benefits all of which were sampled, and 1,000 other transactions of which 10 were sampled. These transactions have an aggregate dollar amount of $373,160.

17. The results for the first group were computed using standard statistical methods for stratified random sample. The results for the second group were based on a simple random sample (these transactions were typically small dollar amounts and mostly involved premium payments to health insurance companies). The result where then combined for both groups.

18. The sampling error was computed as twice the standard error.

NOTE ON DEFINING A AND C GROUPS OF PAYMENT TYPES

The various transactions were categorized between A and C as follows:

Compensability Exam	A
Custodial Day Care	A
Drugs	A
Equipment	C
Family Care	A
Housing	C
Initial Hospital	C
Nursing Care by Other	A
Nursing Care by Parent	A
Parental Award	A
Physician Charges	C
Repeat Hospital	C
Supplies	A
Therapy	C
Transportation & Travel	A
Transportation-Insurance	A
Transportation-Maintenance	A
Transportation-Mileage	A
Transportation-Purchase	C

NOTES ON DEFINING TIME FOR PAYMENT

In the sampling, NICA captured one or more of the following dates for each transaction:

Type	Description
Request	Date NICA was first aware of a request for payment.
Document	Date NICA was presented with supporting documents for the payment
Authorization	Date NICA authorized the request/payment
Invoice	Date on any invoice that was presented to NICA
DOS Start	Date service provided began
DOS End	Date service provided ended
Received	Date an item was received by the beneficiary
Payment	Date payment made

Depending on the availability of the dates and the type of service or product we computed the time to payment as follows:

Custodial Day Care, Family Care, Nursing – Parent, Nursing -Other, Therapy: We measured the time from later of the request, document, invoice, and DOS end date (whichever of these dates was present); to the payment date. We understand that typically the service provider includes a time sheet as documentation and invoice however payment is not made until service has been provided.

Parental Award: We measured the time from the later of the time the award was made and the request date; to the payment data. We understand some parents request their award be paid out periodically rather than as a lump sum, to the payment data.

Repeat Hospital, Supplies: We measured the time from the later of the request and invoice dates, to the payment date.

Transportation-Purchase: We measured the time from the earlier of the request, document, or invoice date; to the earlier of the payment, received or approved date. We believe this reasonably captures any processing delays caused by NICA considering the variety of circumstances involved with a vehicle purchase (e.g., reimbursement for an existing purchase, authorization to make a purchase etc.).

Equipment, Housing (Complex): We measured the time from request to approval. Our understanding that these types of expense typically involve contractor or vendor delays that are out of NICA's control once it has approved the purchase.

Physician Charges, Housing (Simple): We measured time from request to payment.

We varied this process for a handful of transactions with special circumstances. The most significant was for payments to a robotics firm where NICA suggests and leads caregivers to consider the company's products and where the delivery time may be extended due to the customization of the product. For this situation, we measured the time from the invoice date to the payment date.

In all situations, we were guided by the principle that we should measure delays in processing within NICA's control. We tried to exclude delay caused by other contractors or vendors.

Mark Crawshaw

Digitally signed by Mark Crawshaw
Date: 2021.10.21 14:45:43 -04'00'

Mark Crawshaw, Ph.D., FCAS, MAAA
Madison Consulting Group, Inc.
200 North Second Street
Madison, Georgia 30650
(706) 342-7750
mark.crawshaw@madisoninc.com

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

S. Banking & Insurance
Committee

NICA
Bill Number or Topic

Amendment Barcode (if applicable)

Name Brian Meyer

Phone

Address 2727 Mahan Dr.
Street

Email

Tallahassee FL
City State Zip

Speaking: ☐ For ☐ Against ☒ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

NICA
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Susanne Murphy (Deputy Commissioner) Phone

Address Email

Street

City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Office of Insurance Regulation

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

1 Dec 2021
Meeting Date

Banking & Insurance
Committee

N/A
Bill Number or Topic

1
Amendment Barcode (if applicable)

Name Melissa Jaacks

Phone [redacted] 850.488.8191

Address PO Box 14567
Street

Email mjaacks@nica.com

Tallahassee FL 32317
City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

Banking and Insurance
Committee

NICA Auditor General
Audit
Bill Number or Topic

Amendment Barcode (if applicable)

Name Joshua Barrett

Phone 850 412 2804

Address 111 west Madison Street
Street

Email joshuabarrett@aud.state.fl.us

Tallahassee FL 32399
City State Zip

Speaking: ☐ For ☐ Against ☑ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

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 312
INTRODUCER:	Senator Diaz
SUBJECT:	Telehealth
DATE:	November 30, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Favorable**
2.	Johnson	Knudson	BI	**Favorable**
3.			RC	

I. Summary:

SB 312 removes a provision in the definition of "telehealth" that excludes audio-only telephone calls. The bill also amends a provision that, in practice, will allow a telehealth provider to issue a renewal prescription for a controlled substance listed in Schedule III, IV, or V of s. 893.03, F.S., through telehealth, within the scope of his or her practice, and in accordance with other state and federal laws. Currently, telehealth providers are prohibited from prescribing controlled substances through telehealth unless the prescription is for the treatment of a psychiatric disorder, inpatient treatment at a hospital, the treatment of a patient receiving hospice services, or the treatment of a resident in a nursing home facility.[1] The bill narrows this prohibition to the prescribing of only Schedule II controlled substances through telehealth, except under those specific circumstances.

The bill provides an effective date of July 1, 2022.

II. Present Situation:

Telehealth

Relevant Terminology

Section 456.47, F.S., defines the term "telehealth" as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. Section 456.47(1)(a), F.S., provides that the term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

[1] Section 456.47(2)(c), F.S.

"Synchronous" telehealth refers to the live, real-time, or interactive transmission of information between a patient and a health care provider during the same time period. The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

"Asynchronous" telehealth refers to the transfer of data between a patient and a health care provider over a period of time and typically in separate time frames. This is commonly referred to as "store-and-forward."

Florida Telehealth Providers

In 2019, the Legislature authorized Florida-licensed health care providers[2] to use telehealth to deliver health care services within their respective scopes of practice. The bill became effective on July 1, 2019.[3]

The bill also authorized out-of-state health care providers to use telehealth to deliver health care services to Florida patients if they register with the Department of Health (DOH) or the applicable board[4] and meet certain eligibility requirements.[5] A registered out-of-state telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

Telehealth providers who treat patients located in Florida must be one of the licensed health care practitioners listed below[6] and be either Florida-licensed, licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

- Behavioral Analyst
- Acupuncturist
- Allopathic physician
- Osteopathic physician
- Chiropractor
- Podiatrist
- Optometrist
- Nurse
- Pharmacist
- Dentist
- Dental Hygienist
- Midwife
- Speech Therapist

[2] Section 456.47(1)(b), F.S.
[3] Chapter 2019-137, s. 6, Laws of Fla.
[4] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within DOH or, in some cases, within DOH's Division of Medical Quality Assurance.
[5] Section 456.47(4), F.S.
[6] Section 456.47(1)(b), F.S. These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

- Occupational Therapist
- Radiology Technician
- Electrologist
- Orthotist
- Pedorthist
- Prosthetist
- Medical Physicist
- Emergency Medical Technician
- Paramedic
- Massage Therapist
- Optician
- Hearing Aid Specialist
- Clinical Laboratory Personnel
- Respiratory Therapist
- Psychologist
- Psychotherapist
- Dietician/Nutritionist
- Athletic Trainer
- Clinical Social Worker
- Marriage and Family Therapist
- Mental Health Counselor

The Legislature also passed HB 7067 in 2019 that would have required an out-of-state telehealth provider to pay an initial registration fee of $150 and a biennial registration renewal fee of $150. Subsequently, the bill was vetoed by the Governor and did not become law.[7]

On March 16, 2020, Florida Surgeon General Scott Rivkees executed DOH Emergency Order 20-002 authorizing certain out-of-state physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S.[8] Five days later, the Surgeon General executed DOH Emergency Order 20-003[9] to also authorize certain out-of-state clinical social workers, marriage and family therapists, mental health counselors, and psychologists to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S. These state emergency orders were extended and expired on June 26, 2021.[10] Out-of-state health

[7] Transmittal Letter from Governor Ron DeSantis to Secretary of State Laurel Lee (June 27, 2019) *available at* https://www.flgov.com/wp-content/uploads/2019/06/06.27.2019-Transmittal-Letter-3.pdf (last visited Nov. 23, 2021).
[8] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020) *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Nov. 23, 2021).
[9] Department of Health, State of Florida, *Emergency Order DOH No. 20-003* (Mar. 21, 2020) *available at* https://s33330.pcdn.co/wp-content/uploads/2020/03/DOH-EO-20-003-3.21.2020.pdf (last visited Nov. 23, 2021).
[10] Florida Board of Medicine, *Important Updates for Health Care Providers Regarding Expiration of Emergency Orders* (July 1, 2021) *available at* https://r.bulkmail.flhealthsource.gov/mk/mr/JV-U0AMitwBXlP7zcFx3Djqu1KfE1B57JaGN-nnNySmOjEY5xGSsIyII28XjOGeZ4yKv9rWQUryqAibmdrixNZdgE9Q61dmUoHRF1Rnyijg-ewyAl_rZBT8c (last visited Nov. 23, 2021).

care practitioners are no longer authorized to perform telehealth services for patients in Florida unless they become licensed or registered in Florida.

Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[11] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. The Agency for Health Care Administration (AHCA) administers Florida's program and state and federal funds finance the program.[12]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with AHCA under the Statewide Medicaid Managed Care (SMMC) program.[13]

Telemedicine Coverage under the Florida Medicaid Program

Florida Medicaid covers telemedicine in both the managed care and fee-for-service delivery systems. Medicaid health plans have broad flexibility in covering telemedicine services.[14] On January 30, 2020, the U.S. Secretary of the Department of Health and Human Services issued the first declaration of a national public health emergency due to COVID-19; and the declaration remains in effect today.[15] Effective April 3, 2020, and throughout the COVID-19 public health emergency, AHCA will provide for the reimbursement of audio-only telehealth services[16] in the managed care and fee-for-service delivery systems when rendered by licensed physicians

[11] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Nov. 23, 2021).
[12] Section 20.42, F.S.
[13] *Id.*
[14] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Guidance for Medical and Behavioral Health Providers* (Mar. 18, 2020) *available at* https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf (last visited Nov. 23, 2021).
[15] U.S. Department of Health and Human Services, Public Health Emergency Declarations (Oct. 15, 2021) available at https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx (last visited Nov. 23, 2021). The declaration lasts for the duration of the emergency or 90 days; however the Secretary may extend it.
[16] Agency for Health Care Administration, COVID-19 Medicaid Information, available at COVID-19 Alerts Medicaid Information (myflorida.com) (last viewed Nov. 23, 2021).

(including psychiatrists), advanced practice registered nurses, and physician assistants.[17,18] During the public health emergency, Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face.[19]

Under the fee-for service delivery system and in times of non-emergency, Florida Medicaid generally reimburses only for synchronous telemedicine services provided using audio-visual equipment.[20] Effective April 16, 2020, and throughout the public health emergency, AHCA will provide for the reimbursement of audio-only behavioral health services for Medicaid reimbursement under the fee-for service and managed care delivery systems when video capability was not available.[21] As a condition for reimbursement, a behavioral health provider must have documented that the enrollee did not have access to audio and video technology necessary for the service to be fully provided via telemedicine.[22]

The Federal Health Insurance Portability and Accountability Act (HIPAA)[23]

HIPAA Privacy Rule[24]

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. The HIPAA Privacy Rule sets national standards for when protected health information (PHI) may be used and disclosed. Only certain entities and their business associates are subject to HIPAA's provisions. These "covered entities" include health plans, health care providers; and health care clearinghouses.

The Privacy Rule gives individuals privacy and confidentiality rights with respect to their protected PHI, including rights to examine and obtain a copy of their health records in the form and manner they request, and to ask for corrections to their information. In addition, the Privacy Rule permits the use and disclosure of health information needed for patient care and other important purposes.

---

[17] Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-20* (Apr. 3, 2020) *available at* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/2018-23_plan_comm/PT_2020-20_COVID-19_State-of-Emergency_Telemedicine_Services.pdf (last visited Nov. 23, 2021).

[18] 2021 Senate Bill 700 also amended the definition of telehealth in s. 456.47, F.S., to include audio-only telephone calls. Agency for Health Care Administration, *Senate Bill 700 Analysis* (Feb. 15, 2021) (on file with the Senate Committee on Health Policy).

[19] *Id.*

[20] Agency for Health Care Administration, *Senate Bill 852 Analysis* (Feb. 1, 2021) (on file with the Senate Committee on Health Policy).

[21] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Flexibilities for Behavioral Health Providers During the COVID-19 State of Emergency* (Apr. 16, 2020) *available at* https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf (last visited Nov. 23, 2021).

[22] *Id.*

[23] Centers for Medicare & Medicaid Services, *Medicare Learning Network Booklet, HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules* (May. 2021) *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf (last visited Nov. 23, 2021).

[24] 45 C.F.R. Part 160 and Subparts A and E of Part 164.

The Privacy Rule protects PHI held or transmitted by a covered entity or its business associate, in any form, whether electronic, paper, or verbal. PHI includes information that relates to any of the following:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual.

HIPAA Security Rule[25]

The HIPAA Security Rule specifies safeguards that covered entities and their business associates must implement to protect electronic PHI (ePHI) confidentiality, integrity, and availability. Covered entities and business associates must develop and implement reasonable and appropriate security measures through policies and procedures to protect the security of ePHI they create, receive, maintain, or transmit. Each entity must analyze the risks to ePHI in its environment and create solutions appropriate for its own situation. What is reasonable and appropriate depends on the nature of the entity's business as well as its size, complexity, and resources.

Under the Security Rule, covered entities must:

- Ensure the confidentiality, integrity, and availability of all ePHI they create, receive, maintain, or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the ePHI;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance by their workforce.

When developing and implementing Security Rule compliant safeguards, covered entities and their business associates may consider all of the following:

- Size, complexity, and capabilities;
- Technical, hardware, and software infrastructure;
- The costs of security measures; and
- The likelihood and possible impact of risks to ePHI.

Covered entities must review and modify security measures to continue protecting ePHI in a changing environment.

HIPAA Breach Notification Rule[26]

The HIPAA Breach Notification Rule requires covered entities to notify affected individuals; the federal HHS; and, in some cases, the media of a breach of unsecured PHI. Generally, a breach is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.

The impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity demonstrates a low probability that the PHI has been compromised based on a risk assessment of, at a minimum, the following factors:

[25] 45 C.F.R. Part 160 and Subparts A and C of Part 164.
[26] 45 C.F.R. Subpart D.

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

Most notifications must be provided without unreasonable delay and no later than 60 days following the breach discovery. Notifications of smaller breaches affecting fewer than 500 individuals may be submitted to HHS annually. The Breach Notification Rule also requires business associates of covered entities to notify the covered entity of breaches at or by the business associate.

Notification of Enforcement Discretion during Public Health Emergency

Covered health care providers acting in good faith will not be subject to penalties for violations of the HIPAA Privacy Rule, the HIPAA Security Rule, or the HIPAA Breach Notification Rule that occur in the good faith provision of telehealth during the public health emergency.[27] On March 17, 2020, the federal Department of Health & Human Services (HHS) Office for Civil Rights (OCR) issued a Notification of Enforcement of Discretion, meaning that the OCR may exercise its enforcement discretion and not pursue penalties for HIPPA violations against health care providers that serve patients through everyday communication technologies during the public health emergency.[28] If a provider follows the terms of the Notification and any applicable OCR guidance, it will not face HIPAA penalties if it experiences a hack that exposes protected health information from a telehealth session.[29]

Jurisdiction and Venue for Telehealth-related Actions[30]

For purposes of s. 456.47, F.S., any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed or in the patient's county of residence. Venue for a civil or administrative action initiated by the DOH, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider, may be located in the patient's county of residence or in Leon County.

Controlled Substance Prescribing through Telehealth

Controlled Substances Generally

Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act. This chapter classifies controlled substances into five schedules in order to regulate the manufacture, distribution, preparation, and dispensing of the substances. The scheduling of

[27] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (last visited Nov. 23, 2021).
[28] Press Release, U.S. Department of Health and Human Services, *OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency* (Mar. 17, 2021) *available at* https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html (last visited Nov. 23, 2021).
[29] *Supra* note 25.
[30] Section 456.47(5), F.S.

substances in Florida law is generally consistent with the federal scheduling of substances under 21 U.S.C. s. 812:

- A Schedule I substance has a high potential for abuse and no currently accepted medical use in treatment in the United States and its use under medical supervision does not meet accepted safety standards. Examples include heroin and lysergic acid diethylamide (LSD).
- A Schedule II substance has a high potential for abuse, a currently accepted but severely restricted medical use in treatment in the United States, and abuse may lead to severe psychological or physical dependence. Examples include cocaine and morphine.
- A Schedule III substance has a potential for abuse less than the substances contained in Schedules I and II, a currently accepted medical use in treatment in the United States, and abuse may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. Examples include lysergic acid; ketamine; and some anabolic steroids.
- A Schedule IV substance has a low potential for abuse relative to the substances in Schedule III, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule III. Examples include alprazolam, diazepam, and phenobarbital.
- A Schedule V substance has a low potential for abuse relative to the substances in Schedule IV, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule IV. Examples include low dosage levels of codeine, certain stimulants, and certain narcotic compounds.

Federal Law[31]

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008[32] amended the federal Controlled Substances Act, to prohibit a practitioner from issuing a "valid prescription" for a controlled substance through the Internet without having first conducted at least one in-person medical evaluation, except in certain circumstances. Thereafter, the prescriber may prescribe controlled substances to that patient via Internet or a phone call. The Act offers seven exceptions to the in-person exam. One such exception occurs when the Secretary of the federal Department of Health and Human Services (HHS) has declared a public health emergency.

Federal Guidance during the COVID-19 Public Health Emergency

On January 31, 2020, the Secretary of HHS issued a public health emergency.[33] On March 16, 2020, the federal Drug Enforcement Agency (DEA) published a COVID-19 Information page on the Diversion Control Division website, authorizing DEA-registered practitioners, authorized designated DEA-registered practitioners to issue prescriptions for all Schedule II-V controlled substances to patients without first conducting an in-person medical evaluation during the public health emergency, provided all of the following conditions are met:

---

[31] 21 U.S.C. s. 829.
[32] Pub. L. No. 110-425 (2008).
[33] Determination that a Public Health Emergency Exists, Alex M. Azar II, Secretary of U.S. Department of Health and Human Services (January 31, 2020) *available at* https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx (last visited Nov. 23, 2021).

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The evaluation is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable federal and state law.[34]

Florida Law

Under Florida law, controlled substance providers are required to conduct an in-person physical examination prior to issuing a prescription for a controlled substance.[35] During the 2018 legislative session, s. 456.44, F.S., was amended[36] to authorize prescribers to prescribe a three-day supply of a Schedule II opioid[37] or up to a seven-day supply if medically necessary. The prescribing limits on Schedule II opioids do not apply to prescriptions for acute pains related to cancer, a terminal condition, pain treated with palliative care, or a traumatic injury with an Injury Severity Score of 9 or higher.[38]

That section also requires a prescriber and dispenser to report to and review the Prescription Drug Monitoring Program database known as E-FORCSE (Electronic-Florida Online Reporting Controlled Substance Evaluation) to review a patient's controlled substance dispensing history prior to prescribing or dispensing a Schedule II-IV controlled substance for patients 16 years older.[39] These limitations and requirements apply to practitioners providing services in-person and through telehealth.

Section 456.47(2)(c), F.S.,[40] prohibits telehealth providers from prescribing any controlled substance unless the controlled substance is prescribed for:
- The treatment of a psychiatric disorder;
- Inpatient treatment at a licensed hospital;
- The treatment of a patient receiving hospice services; or
- The treatment of a resident of a nursing home facility.

[34] Diversion Control Division, U.S. Department of Justice Drug Enforcement Administration, *COVID-19 Information Page*, *available at* https://www.deadiversion.usdoj.gov/coronavirus.html (last visited Nov. 23, 2021). Letter from Thomas Prevoznik, Deputy Assistant Administrator, Diversion Control Division, U.S. Department of Justice Drug Enforcement Administration, to DEA Qualifying Practitioners and Other Practitioners, (Mar. 31, 2020) *available at* https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf last visited Nov. 23, 2021).
[35] Section 456.44, F.S.
[36] Ch. 2018-13, Laws of Fla.
[37] All opioids are controlled substances. Opioids range in classification between Schedule I and Schedule V.
[38] Section 456.44(1)(a), F.S.
[39] Section 893.055, F.S.
[40] Ch. 2019-137, Laws of Fla.

Florida DOH Emergency Order No. 20-002

The same day that the HHS Secretary authorized qualified prescribers to prescribe Schedule II-V controlled substances, Surgeon General Rivkees issued DOH Emergency Order No. 20-002,[41] which suspended s. 456.47(2)(c), F.S., and authorized specified Florida-licensed prescribers[42] to issue a renewal prescription for a Schedule II-IV controlled substance only for an existing patient for the purpose of treating chronic nonmalignant pain without conducting another physical examination of the patient. This emergency order was extended[43] and expired on June 26, 2021.[44]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 456.47(1)(a), F.S., to remove a provision in the definition of "telehealth" that excludes audio-only telephone calls. This change does not impose a direct impact on Florida Medicaid but would allow Medicaid to elect to reimburse for audio-only telephone calls.

Section 1 of the bill also amends s. 456.47(2)(c), F.S. Currently, telehealth providers are prohibited from prescribing controlled substances through telehealth unless the prescription is for: the treatment of a psychiatric disorder, inpatient treatment at a hospital, the treatment of a patient receiving hospice services, or the treatment of a resident in a nursing home facility. The bill narrows this prohibition to the prescribing of only Schedule II controlled substances through telehealth except under those specific circumstances. In practice, this change will authorize a telehealth provider to issue a renewal prescription for a controlled substance listed in Schedule III, IV, or V of s. 893.03, F.S., through telehealth, within the scope of his or her practice, and in accordance with other state and federal laws.

Under current law, no provider may prescribe a Schedule I drug under any circumstances. Florida law requires a prescriber to perform an in-person physical examination prior to prescribing a controlled substance for the treatment of chronic nonmalignant pain. All prescribers and dispensers of controlled substances must comply with ch. 893, F.S., by consulting and reporting to the Prescription Drug Monitoring Program database.

The applicable board, or DOH if there is no board, may adopt rules to administer this section of statute.[45]

---

[41] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020) *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Nov. 23, 2021).

[42] Physicians, osteopathic physicians, physician assistants, or advanced practice registered nurses that have designated themselves as a controlled substance prescribing practitioner on their practitioner profiles pursuant to s. 456.44, F.S.

[43] Department of Health, State of Florida, *Emergency Order DOH No. 20-011* (June 30, 2020) *available at* https://floridahealthcovid19.gov/wp-content/uploads/2020/06/DOH-Emergency-Order-DOH-No.-20-011.pdf (last visited Nov. 23, 2021).

[44] Florida Board of Medicine, *Important Updates for Health Care Providers Regarding Expiration of Emergency Orders* (July 1, 2021) *available at* https://r.bulkmail.flhealthsource.gov/mk/mr/JV-U0AMitwBXlP7zcFx3Djqu1KfE1B57JaGN-nnNySmOjEY5xGSsIyII28XjOGeZ4yKv9rWQUryqAibmdrixNZdgE9Q61dmUoHRF1Rnyijg-ewyAl_rZBT8c (last visited Nov. 23, 2021).

[45] Section 456.47(7), F.S.

Section 2 of the bill provides an effective date of July 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

According to AHCA, the bill will have an operational impact on the agency that can be absorbed using current resources. Since the bill allows, but does not require, AHCA to reimburse for audio-only telephone calls, there is no fiscal impact to the Florida Medicaid program.[46]

VI. Technical Deficiencies:

None.

[46] Agency for Health Care Administration, *Senate Bill 312 Bill Analysis*, (Oct. 15, 2021) (on file with the Senate Committee on Banking and Insurance).

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 456.47 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 Diaz

36-00376-22 2022312__

A bill to be entitled

An act relating to telehealth; amending s. 456.47, F.S.; revising the definition of the term "telehealth"; narrowing the prohibition on prescribing controlled substances through telehealth to include only specified controlled substances; providing an effective date.

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

Section 1. Paragraph (a) of subsection (1) and paragraph (c) of subsection (2) of section 456.47, Florida Statutes, are amended to read:

456.47 Use of telehealth to provide services.—

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

(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include ~~audio-only telephone calls,~~ e-mail messages~~,~~ or facsimile transmissions.

(2) PRACTICE STANDARDS.—

(c) A telehealth provider may not use telehealth to prescribe a controlled substance listed in Schedule II of s. 893.03 unless the controlled substance is prescribed for the following:

1. The treatment of a psychiatric disorder;

36-00376-22 2022312__

2. Inpatient treatment at a hospital licensed under chapter 395;

3. The treatment of a patient receiving hospice services as defined in s. 400.601; or

4. The treatment of a resident of a nursing home facility as defined in s. 400.021.

Section 2. This act shall take effect July 1, 2022.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/2021		SB 312
Meeting Date		Bill Number or Topic
Committee		Amendment Barcode (if applicable)

Name BARRY GORDON, MD Phone 216-973-7788

Address 711 FRINGED ORCHID Email drbarry@Venicecare.com
Street

VENICE FL 34293
City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12-1-21	SB 312
Meeting Date	Bill Number or Topic
Committee	Amendment Barcode (if applicable)

Name Kevin Hughes MD

Phone 813-391-4891

Address 6313 Balboa Ln
Street

Email hughesfishemd@aol.com

Apollo Beach FL 33572
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[X] I am appearing without compensation or sponsorship.

[ ] I am a registered lobbyist, representing:

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/2021
Meeting Date

SP 312
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Melanie Bone MD

Phone 561-252-2523

Address 2814 S Dixie Hghwy #B
Street

West Palm Bch, FL 33405
City State Zip

Email mbedrmelanie@bone.com

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1
Meeting Date

RI
Committee

312 Rebuttal
Bill Number or Topic

Amendment Barcode (if applicable)

Name DAVID MICA, JR Phone

Address 304 College Ave Email
Street

Tallahassee
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Hospital Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

Banking & Insurance
Committee

~~SB~~ 312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Chris Nuland

Phone 904-233-3051

Address 4427 Herschel St
Street

Email nulandlaw@aol.com

Jacksonville FL 32210
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

Florida Chapter, American College of Physicians

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

Banking & Insurance
Committee

SB 312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Aimee Diaz Lyon

Phone 850-205-9000

Address 119 S. Monroe Street Suite 200
Street

Email adl@mhdfirm.com

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Academy of Family Physicians

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

Banking and Insurance
Committee

SB312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Chris Lyon

Phone 850-222-5702

Address 315 S. Calhoun St. , Ste 830
Street

Email clyon@llw-law.com

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Osteopathic Medical Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

B & I
Committee

312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Mary Thomas

Phone 850-224-6496

Address 1430 Piedmont Dr E
Street

Email MThomas@flmedical.org

TLH FL 32308
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Medical Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

Banking and Insurance
Committee

312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Phillip Swiderman Phone

Address Email

Street

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Americans for Prosperity

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

Banking & Insurance
Committee

SB 312 Telehealth
Bill Number or Topic

Amendment Barcode (if applicable)

Name Tiffany McCaskill Henderson

Phone 850 933 5928

Address [redacted] 2851 Remington Green Circle, Ste A
Street

Email tiffany.henderson@heart.org

Tallahassee, FL 32308
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
American Heart Association
(Government Relations Director)

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

Canty, Amaura

From: Ruiz, Judith
Sent: Wednesday, November 3, 2021 4:54 PM
To: Galea, Kathy; Boyd, Jim; Knudson, James; Canty, Amaura
Subject: SB 312 Telehealth

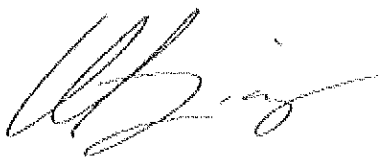
November 3, 2021

Honorable Senator Jim Boyd
Chair
Committee in Banking and Insurance

Honorable Chair Boyd,

I respectfully request SB 312 Telehealth be placed on the next committee agenda.

Telehealth; Revising the definition of the term "telehealth"; narrowing the prohibition on prescribing controlled substances through telehealth to include only specified controlled substances.



Senator Manny Diaz, Jr.
Florida Senate, District 36

CC: James Knudson, Staff Director
Amaura Canty, Committee Administrative Assistant
Kathy Galea, Legislative Assistant

Legislative Assistant/Chief of Staff
District 36
Senator Manny Diaz Jr.
10001 NW 87 Avenue
Hialeah, Florida 33016
305-364-3073

306 Senate Building
404 South Monroe Street
Tallahassee, Fl 32399-1100
850-487-5036

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 468
INTRODUCER:	Banking and Insurance Committee and Senator Perry
SUBJECT:	Insurance
DATE:	December 2, 2021
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 468 amends several insurance-related statutes. Specifically, the bill:

- Directs the Florida Hurricane Catastrophe Fund to provide reimbursement for a loss under collateral protection insurance (also known as lender-placed or force-placed insurance) when the coverage amount differs from the coverage amount under the lapsed policy if the homeowner received notice of the collateral protection insurance coverage amount, or the homeowner requested a different coverage amount from the collateral protection insurer.
- Provides that current requirements under the Workers' Compensation Law for annual, physical onsite payroll audits of employers in the construction class for new and renewal policies will only apply when the estimated annual premium is $10,000 or more.
- Provides that service of process is valid and binding on an insurer upon delivery of the process documents to the insurer or upon the insurer receiving notice that the information is available on a secured network.
- Authorizes associations, trusts, and pools formed to provide self-insurance for public entities to establish a quorum and conduct public business through communications media technology.
- Provides that an all-lines adjuster who is appointed and employed by an insurer's affiliate may serve as a company employee adjuster for the purpose of adjusting claims.
- Allows a residential property insurer's rate filing to estimate projected hurricane losses by using a weighted or straight average of two or more models approved by the Florida Commission on Hurricane Loss Projection Methodology.

- Authorizes an insurer to file a personal lines residential property insurance rating plan that provides premium discounts, credits, and other rate differentials based on windstorm construction standards developed by an independent, not-for-profit, scientific research organization.
- Limits the requirement that an insurer must provide a policyholder who has an automatic bank withdrawal agreement with the insurer with 15 days advance written notice of any increase in policy premiums. Instead, notice will only be required for premium increases that will result in an increase in the automatic withdrawal of more than $10 from the previous withdrawal amount.
- Provides Citizens Property Insurance Corporation with discretion to offer wind-only policies to condominium associations when 50 percent or more of their units are rented more than eight times per year for a period of less than 30 days.
- Eliminates a requirement that an insurer that provides electronic delivery of the insurance policy to a policyholder (or the person entitled to delivery) must also provide within the electronic transmission notice of the policyholder's right to receive the policy via United States mail. Also eliminates a requirement that the insurer provide a paper copy of the policy to the insured upon his or her request.
- Allows a policyholder to select a hurricane deductible greater than 10 percent, reject windstorm coverage, or reject contents coverage under a residential property insurance policy by typing the existing exclusionary statement language, instead of handwriting it.
- Provides that s. 627.7152, F.S., governing assignment agreements, applies to instruments that assign or transfer post-loss benefits to a service provider that provides scopes of service or provides inspection services.
- Provides that the term "assignment agreement" does not include an instrument by which a licensed public adjuster is compensated for public adjuster services.
- Requires that an assignee must provide the notice of intent to initiate litigation to the name and mailing address designated by the insurer in the policy forms if notice is sent by certified mail, return receipt requested, or to the e-mail address designated by the insurer in the policy forms if notice is sent by electronic delivery.
- Requires that an automobile policy that does not provide coverage for bodily injury liability and property damage liability include notice accompanying the declarations page that the policy does not provide such coverages and does not comply with any financial responsibility laws. Such policies generally cover antique motor vehicles.
- Authorizes the exemption of licensed personal lines and general lines agents from salesperson licensing requirements to solicit, negotiate, advertise, or sell motor vehicle service agreements, home warranty contracts, and service agreement contracts.

The bill takes effect July 1, 2022, except as otherwise provided.

II. Present Situation:

The Florida Hurricane Catastrophe Fund (FHCF)

The FHCF is a tax-exempt[1] fund created in 1993[2] after Hurricane Andrew[3] as a form of mandatory reinsurance for residential property insurers. The FHCF is administered by the State Board of Administration (SBA)[4] and is a tax-exempt source of reimbursement to property insurers for a selected percentage (45, 75, or 90 percent)[5] of hurricane losses above the insurer's retention (deductible). The FHCF provides insurers an additional source of reinsurance that is less expensive than what is available in the private market, enabling insurers to generally write more residential property insurance in the state than would otherwise be written. Because of the low cost of coverage from the FHCF, the fund acts to lower residential property insurance premiums for consumers.

All insurers admitted to do business in this state writing residential property insurance, that includes wind coverage, must buy reimbursement coverage (reinsurance) on their residential property exposure through the FHCF.[6] The FHCF is authorized by statute to sell $17 billion of mandatory layer coverage.[7] Each insurer that purchases coverage may receive up to its proportional share of the $17 billion mandatory layer of coverage based upon the insurer's share of the actual premium paid for the contract year, multiplied by the claims paying capacity of the fund. Each insurer may select a reimbursement contract wherein the FHCF promises to reimburse the insurer for 45 percent, 75 percent, or 90 percent of covered losses, plus 10 percent[8] of the reimbursed losses for loss adjustment expenses.[9]

The FHCF must charge insurers the actuarially indicated premium[10] for the coverage provided, based on hurricane loss projection models found acceptable by the Florida Commission on Hurricane Loss Projection Methodology.[11] The actuarially indicated premium is an amount determined by the principles of actuarial science to be adequate to pay current and future obligations and expenses of the fund.[12] In practice, each insurer pays the FHCF annual reimbursement premiums that are proportionate to each insurer's share of the FHCF's risk exposure. Historically, FHCF coverage generally costs less than private reinsurance because the fund is a tax-exempt non-profit corporation and does not charge a risk load as it relates to overhead and operating expenses incurred by other private insurers.[13]

---

[1] Section 215.555(1)(f), F.S.
[2] Chapter 93-409, Laws of Fla.
[3] Ed Rappaport, *Preliminary Report, Hurricane Andrew* (updated Dec. 10, 1993; addendum Feb. 7, 2005), https://www.nhc.noaa.gov/1992andrew.html.
[4] State Board of Administration of Florida, *About the SBA*, https://www.sbafla.com/fsb/ (last visited March 23, 2021).
[5] Section 215.555(2)(e), F.S.
[6] *See* s. 215.555(4)(a), F.S.
[7] Section 215.555(4)(c)1., F.S.
[8] Section 215.555(4)(b)1., F.S.
[9] Loss adjustment expenses are costs incurred by insurers when investigating, adjusting, and processing a claim.
[10] Section 215.555(5)(a), F.S.
[11] *See*, *Florida Commission on Hurricane Loss Methodology*, https://www.sbafla.com/method/ (last visited March 23, 2021).
[12] Section 215.555(2)(a), F.S.
[13] State Board of Administration of Florida, Florida Hurricane Catastrophe Fund, *2016 Annual Report*, https://www.sbafla.com/fhcf/Portals/FHCF/Content/Reports/Annual/20170606_FHCF_2016_AnnualReport_A.pdf?ver=2017-07-06-085215-943 (last visited March 8, 2021).

When the moneys in the FHCF are or will be insufficient to cover losses, the law[14] authorizes the FHCF to issue revenue bonds funded by emergency assessments on all lines of insurance except medical malpractice and workers compensation.[15] Emergency assessments may be levied up to 6 percent of premium for losses attributable to any one contract year, and up to 10 percent of premium for aggregate losses from multiple years. The FHCF's broad-based assessment authority is one of the reasons the FHCF was able to obtain an exemption from federal taxation from the Internal Revenue Service as an integral part of state government.[16]

Reimbursement of Collateral Protection Insurance

Collateral protection insurance, sometimes referred to as "lender-placed" or "force-placed" insurance, is insurance that is placed by a lender, at the expense of the borrower, to protect the lender's security interest in property pursuant to a loan, such as a home mortgage. Collateral protection insurance is placed by the lender when it deems the homeowners' insurance insufficient, usually because the borrower's insurance policy is lapsed or cancelled. The FHCF covers policies of collateral protection insurance if the collateral protection insurance covers a personal residence and protects both the borrower's and the lender's financial interests in an amount at least equal to the coverage for the dwelling in place under the lapsed homeowners policy.[17]

Payroll Audits for Construction Classification of Employers

Florida law currently requires biennial payroll audits for employers in all classes other than construction, with factors for more frequent audits, and annual, physical onsite payroll audits for employers in the construction class, to ensure that the appropriate premium is charged for workers' compensation coverage.[18] Section 440.381, F.S., does not provide a minimum premium threshold for compliance purposes.

An employer that fails to provide reasonable access to payroll records for an audit must pay the insurer a premium not to exceed three times the most recent estimated annual premium.[19] An employer that understates or conceals payroll, misrepresents or conceals employee duties so as to avoid proper classification for premium calculations, or misrepresents or conceals information pertinent to the computation and application of an experience rating modification factor, must pay the insurer a penalty equal to 10 times the amount of the difference in premium paid and the amount the employer should have paid, plus reasonable attorney's fees.[20]

---

[14] Section 215.555(6), F.S.
[15] Section 215.555(6)(b), F.S.
[16] The U.S. Internal Revenue Service has, by a Private Letter Ruling, authorized the FHCF to issue tax-exempt bonds. The initial ruling was granted on March 27, 1998, for 5 years until June 30, 2003. On May 28, 2008, the Internal Revenue Service issued a private letter ruling holding that the prior exemption, which was to expire on June 30, 2008, could continue to be relied upon on a permanent basis. See Florida Hurricane Catastrophe Fund, *Fiscal Year 2009-2010 Annual Report*, 14, https://www.sbafla.com/fhcf/Portals/FHCF/Content/Reports/Annual/SBA_CATF_Annual_ReportFHCF_Final.pdf?ver=2016-06-08-121900-647 (last visited March 23, 2021).
[17] Section 215.555(2)(c), F.S.
[18] Section 440.381(3), F.S.
[19] Section 440.381(8), F.S.
[20] Section 440.381(6)(a), F.S.

The Chief Financial Officer as Agent for Service of Process on Insurers

Florida's Chief Financial Officer[21] (CFO) is the agent for service of process on all insurers applying for authority to transact insurance in this state, all licensed nonresident insurance agents, all nonresident disability insurance agents licensed pursuant to s. 626.835, F.S., any unauthorized insurer under s. 626.906, F.S. or s. 626.937, F.S., domestic reciprocal insurers, fraternal benefit societies under ch. 632, F.S., warranty associations under ch. 634, F.S., prepaid limited health service organizations under ch. 636, F.S., and persons required to file statements under s. 628.461, F.S.[22]

Service of process on the CFO is made by mail, personal service, or internet-based transmission system created by the Department of Financial Services (DFS).[23] Upon receiving service of process, the CFO retains a record copy in paper or electronic form and promptly forwards one copy of the process documents to the insurer's designated process agent by registered or certified mail.[24] The CFO may also make the process documents available from a secure website created by DFS and provide notice of availability and retrieval instructions to the insurer's designated process agent under s. 624.307(9), F.S.

Under current law, service of process is considered valid and binding service on the insurer at such time as the process documents are served on the CFO and sent or made available to the insurer pursuant to s. 624.307(9), F.S., rather than at such time the process documents are received by the insurer.[25] The CFO has advised the Office of State Courts Administrator as much in communication advising of its role as the statutorily-designated process agent for insurers.[26]

Recent court cases have addressed similar questions related to whether service of process on an insurer is perfected at the time served on the CFO or at the time received by the insurer. For example, in *Markovits*,[27] an uninsured motorist lawsuit that also involved an award of attorney fees for a rejected proposal for settlement, the court was asked to determine whether a proposal for settlement served on the insurer 91 days after service of the complaint on the CFO but 88 days after the complaint was forwarded by the CFO to the insurer, constituted valid service within a 90-day deadline for proposals for settlement on the insurer. In addition to finding statutory authority under s. 624.423(3), F.S., the court ultimately based its decision on s. 48.151(1), F.S., relating to service on statutory agents for certain persons, citing in part "[w]hen any law designates a public officer, board, agency, or commission as agent for service of process" and the person or entity so designated is served with process, then "service is valid service for all purposes," and holding that service of process is considered valid and binding on the insurer when served on the CFO.[28]

[21] The CFO's assistant, deputy, or another person in charge of the office may also serve as the agent for service of process.
[22] Section 48.151(3), F.S.
[23] Id.
[24] Section 624.423(1), F.S.
[25] Section 624.423(3), F.S.
[26] Letter to office of State Courts Administrator from John MacIver, General Counsel for DFS (June 22, 2020)(on file with the Senate Committee on Banking and Insurance).
[27] *Markovits v. Stater Farm Mutual Automobile Insurance*, 235 So.3d 1018 (Fla. 1st DCA 2018).
[28] *Markovitz* at 1020.

Electronic Meetings for Public Self-Insurers

Florida law authorizes two or more local governmental entities to enter into an interlocal agreement (fund) for the purpose of securing workers' compensation payments, or insuring or self-insuring real or personal property of every kind and every interest in such property against loss or damage from any hazard or cause and against any loss consequential to such loss or damage.[29]

For any fund created after October 1, 2004, the fund is subject to the requirements of group self-insurance funds for the first 5 years of its existence,[30] including participation in the Florida Self-Insurance Guaranty Association.[31] The Florida Self-Insurers Guaranty Association is exempt from certain public record requirements under s. 119.07(1), F.S., related to claims and minutes meetings, and certain public meeting requirements under s. 286.011, F.S.,[32] related to discussion to claims and other confidential information. Section 286.011, F.S., declares all meetings of any board or commission of any state agency or authority or of any agency or authority of any county, municipal corporation, or political subdivision, except as otherwise provided in the Constitution, including meetings with or attended by any person elected to such board or commission, but who has not yet taken office, at which official acts are to be taken to be public meetings open to the public at all times. Any resolution, rule, or formal action taken in contravention of this provision is not considered binding.[33]

Insurance Adjusters

Florida law requires all insurance adjusters to be licensed by DFS and appointed by the appropriate entity or person[34] in order to adjust claims. General requirements for licensure include submitting an application; paying required fees; satisfying pre-licensing examination requirements, when applicable; complying with requirements as to knowledge, experience, or instruction; and submitting fingerprints.[35]

Under s. 626.864, F.S., there are both public adjusters and all-lines adjuster license types, with all-lines appointments further divided into independent adjusters,[36] company employee adjusters,[37] and public adjuster apprentices.[38] The same adjuster may not be concurrently licensed as a public adjuster and an all-lines adjuster.[39] In the case of an all-lines adjuster, the adjuster may be appointed as an independent adjuster, company employee adjuster, or public adjuster apprentice, but not more than one concurrently.[40]

---

[29] Section 624.4622(1), F.S.
[30] Section 624.4622(3). F.S.
[31] Section 624.4621(9).
[32] Section 440.3851, F.S.
[33] Section 286.011, F.S.
[34] *See* s. 626.015(4), F.S., defining "appointment" as the authority given by an insurer or employer to a licensee to adjust claims on behalf of an insurer or employer.
[35] Section 626.171, F.S.
[36] Section 626.855, F.S.
[37] Section 626.856, F.S.
[38] Section 626.8561, F.S.
[39] Section 626.864(2), F.S.
[40] Section 626.864(3), F.S

A public adjuster is any person, other than a licensed attorney, who, for compensation, prepares, completes, or files an insurance claim form for an insured or third-party claimant in negotiating or settling an insurance claim on behalf of an insured or third party.[41] Public adjusters operate independently and are not affiliated with any insurer.

An all-lines adjuster is any person who, for compensation, ascertains and determines the amount of any claim, loss, or damage payable under an insurance contract or settles such claim, loss, or damage on behalf of a public adjuster or insurer.[42]

An independent adjuster is any person who is self-employed or employed by an independent adjusting firm and who works for an insurer to ascertain and determine the amount of an insurance claim, loss, or damage, or to settle an insurance claim under an insurance contract.[43]

A company employee adjuster is any person employed in-house by an insurer, or a wholly owned subsidiary of the insurer, who ascertains and determines the amount of an insurance claim, loss, or damage, or settles such claim, loss or damage.[44]

Regulation of Property Insurance Rates

Part I of ch. 627, F.S., is the Rating Law[45] governing property, casualty, and surety insurance which covers subjects of insurance resident, located, or to be performed in this state.[46] The Rating Law provides that the rates for all classes of insurance it governs may not be excessive, inadequate, or unfairly discriminatory.[47] Though the terms "rate" and "premium" are often used interchangeably, the rating law specifies that "rate" is the unit charge that is multiplied by the measure of exposure or amount of insurance specified in the policy to determine the premium, which is the consideration paid by the consumer.[48]

All insurers or rating organizations must file rates with the Office of Insurance Regulation (OIR) either 90 days before the proposed effective date of a new rate, which is considered a "file and use" rate filing, or 30 days after the effective date of a new rate, which is considered a "use and file" rate filing.

Upon receiving a rate filing, the OIR reviews the filing to determine if the rate is excessive, inadequate, or unfairly discriminatory. The office makes that determination in accordance with generally acceptable actuarial techniques and, in a property insurance rate filing, considers the following:

- Past and prospective loss experience.
- Past and prospective expenses.

[41] Section 626.854(1), F.S.
[42] Section 626.8548, F.S.
[43] Section 626.855, F.S.
[44] Section 626.856, F.S.
[45] Section 627.011, F.S.
[46] Section 627.021, F.S.
[47] Section 627.062(1), F.S.
[48] Section 627.041, F.S.

- The degree of competition among insurers for the risk insured.
- Investment income reasonably expected by the insurer.
- The reasonableness of the judgment reflected in the rate filing.
- Dividends, savings, or unabsorbed premium deposits returned to policyholders.
- The adequacy of loss reserves.
- The cost of reinsurance.
- Trend factors, including trends in actual losses per insured unit for the insurer.
- Conflagration and catastrophe hazards.
- Projected hurricane losses.
- Projected flood losses, if the policy covers the risk of flood.
- A reasonable margin for underwriting profit and contingencies.
- Other relevant factors that affect the frequency or severity of claims or expenses.

Florida Commission on Hurricane Loss Projection Methodology

Projected hurricane losses in a rate filing must be estimated using a model or method found to be acceptable or reliable by the Florida Commission on Hurricane Loss Projection Methodology.[49] The commission consists of 12 members with expertise in the elements that are used to develop computer models to estimate hurricane and flood loss. Members of the commission include State University System faculty experts in insurance finance, statistics, computer system design, meteorology, and structural engineering; three actuaries; the insurance consumer advocate; the director of the FHCF; the Executive Director of Citizens Property Insurance Corporation; and the Director of the Division of Emergency Management.[50]

Residential Property Insurance Mitigation Credits, Discounts, or Other Rate Differentials

Residential property insurance rate filings must account for mitigation measures undertaken by policyholders to reduce hurricane losses.[51] Specifically, the rate filings must include actuarially reasonable discounts, credits, or other rate differentials or appropriate reductions in deductibles to consumers who implement windstorm damage mitigation techniques to their properties.[52] Upon their filing by an insurer or rating organization, OIR determines the discounts, credits, other rate differentials and appropriate reductions in deductibles that reflect the full actuarial value of such revaluation,[53] which in turn may be used in rate filings under the Rating Law. Windstorm mitigation measures that must be evaluated for purposes of mitigation discounts include fixtures or construction techniques that enhance roof strength; roof covering performance, roof-to-wall strength; wall-to-floor foundation strength; opening protections; and window, door, and skylight strength.[54]

[49] Section 627.062(2)(b)11., F.S.
[50] Section 627.0628(2)(b), F.S.
[51] Section 627.062(2)(j), F.S.
[52] Section 627.0629(1), F.S.
[53] *Id*.
[54] *Id*.

Automatic Bank Withdrawal Agreements in the Insurance Context

Florida law allows insurers and policyholders to enter into automatic bank withdrawal agreements for the purpose of paying insurance premiums.[55] Policyholders generally have the option of selecting between payment plans that divide the premium into two or four separate payments or in monthly installments. Under current law, insurers must provide the policyholder with 15 days advance written notice prior to any automatic bank withdrawal if the premium payment increases from the previous withdrawal period by any amount.

By contrast, federal law requires financial institutions to provide 10 days advance written notice prior to any automatic bank withdrawal either when the amount varies from the previous withdrawal amount, when the amount varies outside a specified range of amounts, or when the amount varies from the previous withdrawal amount by an agreed-upon amount.[56]

Citizens Property Insurance Corporation (Citizens)

Citizens is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide affordable property insurance coverage to those unable to find coverage in the voluntary admitted market.[57] Citizens is not a private insurance company.[58] Citizens was statutorily created in 2002 when the Legislature combined the state's two insurers of last resort, the Florida Residential Property and Casualty Joint Underwriting Association (RPCJUA) and the Florida Windstorm Underwriting Association (FWUA). Citizens operates in accordance with the provisions in s. 627.351(6), F.S., and is governed by a nine-member Board of Governors[59] that administers its Plan of Operations. The Plan of Operations is reviewed and approved by the Financial Services Commission. The President of the Senate, Speaker of the House of Representatives, and Chief Financial Officer each appoints two members to the board. The Governor appoints three members to the board, one of whom serves solely to advocate for consumers. Citizens is subject to regulation by the OIR.

Citizens offers property insurance in three separate accounts. Each account is a separate statutory account with separate calculations of surplus and deficits.[60] Assets may not be commingled or used to fund losses in another account.[61]

- **The Personal Lines Account (PLA)** offers personal lines residential policies that provide comprehensive, multiperil coverage statewide, except for those areas contained in the Coastal Account. The PLA also writes policies that exclude coverage for wind in areas contained within the Coastal Account. Personal lines residential coverage consists of the types of coverage provided to homeowners, mobile homeowners, dwellings, tenants, and condominium unit owner's policies.

[55] Section
[56] 12 CFR 1005.10(d)
[57] Admitted market means insurance companies licensed to transact insurance in Florida.
[58] Section 627.351(6)(a)1., F.S. Citizens is also subject to regulation by the OIR.
[59] The Governor, the Chief Financial Officer, the President of the Senate, and the Speaker of the House of Representatives each appoint two members.
[60] The Personal Lines Account and the Commercial Lines Account are combined for credit and Florida Hurricane Catastrophe Fund coverage.
[61] Section 627.351(6)(b)2b., F.S.

- **The Commercial Lines Account (CLA)** offers commercial lines residential and nonresidential policies that provide basic perils coverage statewide, except for those areas contained in the Coastal Account. The CLA also writes policies that exclude coverage for wind in areas contained within the Coastal Account. Commercial lines coverage includes commercial residential policies covering condominium associations, homeowners' associations, and apartment buildings. The coverage also includes commercial nonresidential policies covering business properties.
- **The Coastal Account** offers personal residential, commercial residential, and commercial non-residential policies in coastal areas of the state. Citizens must offer policies that solely cover the peril of wind (wind only policies) and may offer multiperil policies.[62]

Citizens Eligibility for Commercial Residential Wind-Only Coverage

In 2014,[63] the Legislature enacted changes to the statutes governing Citizens that prohibited residential condominium associations from obtaining commercial residential property insurance policies from Citizens which cover damage only from wind if 50 percent or more of the condominiums in the association are rented more than eight times a year for less than 30 days. These changes were intended to provide clarity to the classification of transient occupancy risks and remove inconsistencies between commercial residential and commercial non-residential properties.[64] Condominiums are presently able to obtain Citizens policies that cover damage from multiple perils, including wind.

Delivery of Insurance Policies and Claims Communications

Under s. 627.421, F.S., Florida law currently requires most insurers[65] to deliver, mail, or electronically transmit the insurance policy to the policyholder within 60 days of such coverage taking effect. Policyholders of personal lines policies may elect electronic transmission of policy documents; however, for commercial lines policies, policy documents are sent via electronic transmission unless the policyholder declines electronic transmission by written or electronic communication to the insurer. The policyholder is further entitled to a paper copy of the policy upon request.[66] An insurer that electronically transmits policy documents must include notice of the right to receive a paper copy of the policy via United States mail.[67]

Florida law varies with respect to electronic and nonelectronic transmission of claims communications. In some cases, e.g, written proof of loss, claims communications must be

[62] In August of 2007, Citizens began offering personal and commercial residential multiperil policies in this limited eligibility area. Additionally, near the end of 2008, Citizens began offering commercial non-residential multiperil policies in this account.
[63] Chapter 2015-140, L.O.F.
[64] House Regulatory Affairs Committee, *House Bill 1089 Analysis* (June 16, 2014) https://www.flsenate.gov/Session/Bill/2014/1089/Analyses/h1089z1.IBS.PDF (last visited February 8, 2021).
[65] Part II of ch. 627, F.S., exempts reinsurers, wet marine and transportation, title, and credit life of credit disability insurers from the delivery provisions of s. 627.421, F.S.
[66] Section 627.421(1), F.S.
[67] *See* Id.

nonelectronic,[68] while on others, e.g. payment of health insurance claims, claims communication may be electronic or nonelectronic.[69]

Affirmative Exclusions of Property Insurance Deductibles and Coverages

A hurricane deductible is the amount paid by the policyholder before the insurer issues any payment for damaged caused by a hurricane.[70] Under Florida law, the hurricane deductible is capped at 10 percent of the policy dwelling limits for a covered risk valued at less than $500,000, unless the policyholder affirmatively rejects the statutory hurricane deductible limit.[71] In order to do so, the policyholder must personally write and provide the insurer the following statement in his or her own handwriting: "I do not want the insurance on my home to pay for the first (specify dollar value) of damage from hurricanes. I will pay those costs. My insurance will not." Furthermore, the policyholder and each named insured on the policy must sign and date the statement.[72]

Florida law also requires a residential property insurance policy to include windstorm coverage[73], unless the policyholder affirmatively rejects the coverage.[74] If the policyholder is a natural person, the policyholder must personally write and provide the insurer the following statement in his or her own handwriting: "I do not want the insurance on my home (home/mobile home/condominium unit) to pay for damage from windstorms. I will pay those costs. My insurance will not." Furthermore, the policyholder and each named insured on the policy must sign and date the statement.[75]

A similar provision exists in statute for exclusion of contents coverage under a residential property insurance policy, except for a condominium unit owner policy or a tenant policy. Under s. 627.712(3), F.S., the policyholder must personally write and provide the insurer the following statement in his or her own handwriting: "I do not want the insurance on my home (home/mobile) to pay for costs to repair or replace any contents that are damaged. I will pay those costs. My insurance will not." Furthermore, the policyholder and each named insured on the policy must sign and date the statement.

Assignment of Post-Loss Benefits Under a Property Insurance Policy

An assignment is the voluntary transfer of the rights of one party under a contract to another party. Current law generally allows an insurance policyholder to assign the benefits of the policy,

[68] Section 627.425, F.S.
[69] Section 627.6131, F.S.
[70] Department of Financial Services, *Florida's Hurricane Deductible* https://www.myfloridacfo.com/division/consumers/floridashurricanedeductible.htm (last visited November 23, 2021).
[71] Section 627.701(4)(d), F.S.
[72] *See* Id.
[73] This require does not apply to a risk that is eligible for wind-only coverage from Citizens Property Insurance Corporation. Nor does the requirement apply to a risk that is ineligible for Citizens coverage because the risk: (1) is a structure that has a dwelling replacement cost of $700,000; (2) is a single condominium unit with a combined dwelling and contents replacement cost of $700,000 or more; or (3) is located in the "wind-borne" debris region as defined in s. 1609.2 of the International Building Code (2006) and has an insured value on the structure of $750,000 or more.
[74] Section 627.712, F.S.
[75] Section 627.712(2)(a)1, F.S.

such as the right to be paid, to another party. This assignment is often called an "assignment of benefits" or "AOB." Once an assignment is made, the assignee can take action to enforce the contract. Accordingly, if the benefits are assigned and the insurer refuses to pay, the assignee may file a lawsuit against the insurer to recover the insurance benefits.[76]

The Legislature in 2019 enacted s. 627.7152, F.S., which governs the execution of assignment of post-loss benefits under a property insurance policy, provides duties that assignees must meet when filing a claim under a property insurance policy, provides requirements pursuant to litigation brought by assignees under property insurance policies, and revises the standards for awarding attorney fees in such litigation. An assignment agreement is any instrument that effectuates the assignment, transfer, or acquisition of post-loss benefits to or from a person providing services to protect, repair, restore, or replace property, or to mitigate against further damage to the property.

Prior to litigation, under s. 627.7152(9), F.S., an assignee must provide the named insured and the assignor a written notice of intent to initiate litigation, delivered at least 10 business days before filing suit, but not before the insurer has made a determination of coverage. The notice must also include a detailed written invoice or estimate of services that includes itemized information and proof work was performed in accordance with accepted industry standards. In a claim arising under an assignment agreement, the assignee has the burden under s. 627.7152(3)(b), F.S., to demonstrate that the insurer is not prejudiced by the assignee's failure to cooperate with the insurer in the claim investigation.

Notice of Limited Coverage for Antique Vehicles

Some insurers[77] offer motor vehicle insurance coverage for antique vehicles[78] that does not include mandatory personal injury protection[79] and property damage liability[80] coverages, in which case Florida law requires the automobile policy to provide notice to the policyholder of the limited coverage and its noncompliance with any financial responsibility law.[81] Such coverage is generally appropriate for antique vehicles that are stored in a private collection or as part of a public display and are not driven on the roadways of this state. Such notice must be stamped or printed in contrasting color from the color used on the policy and placed on the policy declaration page and on the back of the policy.[82]

[76] *Nationwide Mutual Insurance Company v. Pinnacle Medical, Inc.* 753 So.2d 55, 57 (Fla. 2000)("The right of assignee to sue for breach of contract to enforce assigned rights predates the Florida Constitution").
[77] https://www.statefarm.com/insurance/auto/antique-classic-cars (last visited November 29, 2021).
[78] *See* section 320.086, F,S.
[79] Section 627.733, F.S.
[80] Section 324.022, F.S.
[81] Section 627.7276(1), F.S.
[82] Section 627.7276(2), F.S.

Agent Licensing

General Lines Agent

A general lines agent[83] is one who sells the following lines of insurance: property;[84] casualty,[85] including commercial liability insurance underwritten by a risk retention group, a commercial self-insurance fund,[86] or a workers' compensation self-insurance fund;[87] surety;[88] health;[89] and marine.[90] The general lines agent may only transact health insurance for an insurer that the general lines agent also represents for property and casualty insurance.[91] If the general lines agent wishes to represent health insurers that are not also property and casualty insurers, they must be licensed as a health insurance agent.[92]

Personal Lines Agent

A personal lines agent is a general lines agent who is limited to transacting business related to property and casualty insurance sold to individuals and families for noncommercial purposes.[93]

Motor Vehicle Servicing Agreements

Motor vehicle service agreements provide vehicle owners with protection when the manufacturer's warranty expires. A motor vehicle service agreement indemnifies the vehicle owner (or holder of the agreement) against loss caused by failure of any mechanical or other component part, or any mechanical or other component part that does not function as it was originally intended.[94] Motor vehicle service agreements can only be sold by a licensed and appointed salesperson.[95] Salespersons are licensed in the same manner as insurance representatives under ch. 626, F.S., with some exceptions to the requirements applied to insurance representatives.[96]

Home Warranty Contracts

A home warranty is any contract or agreement whereby a person undertakes to indemnify the warranty holder against the cost of repair or replacement, or actually furnishes repair or replacement, of any structural component or appliance of a home, necessitated by wear and tear or an inherent defect of any such structural component or appliance or necessitated by the failure of an inspection to detect the likelihood of any such loss.[97] No person shall solicit, negotiate, or

[83] Section 626.015(7), F.S.
[85] Section 624.605, F.S.
[85] Section 624.605, F.S.
[86] As defined in s. 624.462, F.S.
[87] Pursuant to s. 624.4621, F.S.
[88] Section 626.606, F.S.
[89] Section 624.603, F.S.
[90] Section 624.607, F.S.
[91] Section 626.827, F.S.
[92] Section 626.829, F.S.
[93] Section 626.015(17), F.S.
[94] Section 634.011(8), F.S.
[95] Section 634.031, F.S.
[96] Section 634.171, F.S.
[97] Section 634.301, F.S.

effectuate home warranty contracts for remuneration in this state unless such person is licensed and appointed as a sales representative.[98]

Service Warranty Contracts

A service warranty is an agreement or maintenance service contract equal to or greater than 1 year in length to repair, replace, or maintain a consumer product, or for indemnification for repair, replacement, or maintenance, for operational or structural failure due to a defect in materials or workmanship, normal wear and tear, power surge, or accidental damage from handling in return for the payment of a segregated charge by the consumer.[99] A person or entity may not solicit, negotiate, advertise, or effectuate service warranty contracts in this state unless the person or entity is licensed and appointed as a sales representative.[100]

III. Effect of Proposed Changes:

Collateral Protection Insurance

Section 1 amends s. 215.555, F.S., to require that the FHCF provide reimbursement for a loss under collateral protection insurance (also known as lender-placed or force-placed insurance) when the coverage amount differs from the coverage amount under the lapsed policy if the homeowner received notice of the collateral protection insurance coverage amount, or the homeowner requested a different coverage amount from the collateral protection insurer.

This section is effective June 1, 2023.

Payroll Audits for Construction Classification of Employers

Section 2 amends s. 440.381, F.S., governing payroll audits, provide that current requirements under the Workers' Compensation Law for annual, physical onsite payroll audits of employers in the construction class for new and renewal policies will only apply when the estimated annual premium is $10,000 or more

Service of Process

Section 3 amends s. 624.423, F.S., to provide that service of process is considered valid and binding on the insurer at the time the process documents are received by, rather than sent to, the insurer. Additionally, the section incorporates the secured network process provided for under s. 624.307(9), F.S., by providing that process is valid and binding upon being made available on the system.

[98] Section 634.317, F.S. "sales representative" is any person with whom an insurer or home inspection or warranty association has a contract and who is utilized by such insurer or association for the purpose of selling or issuing home warranties. The term includes all employees of an insurer or association engaged directly in the sale or issuance of home warranties. Section 634.301(12), F.S.
[99] Section 634.401(13), F.S.
[100] Section 634.419, F.S. A "sales representative" is any person, retail store, corporation, partnership, or sole proprietorship utilized by an insurer or service warranty association for the purpose of selling or issuing service warranties. However, in the case of service warranty associations selling service warranties from one or more business locations, the person in charge of each location may be considered the sales representative. Section 634.401(12), F.S.

This section is effective upon becoming law.

Electronic Meetings of Self-Insured Public Entities

Section 4 creates s. 624.46227, F.S., to authorize associations, trusts, and pools formed to provide self-insurance for public entities to establish a quorum and conduct public business through communications media technology.

Company Employee Adjusters

Section 5 amends s. 626.856, F.S., revising the definition of a "company employee adjuster" in the Insurance Adjusters Law, to provide that an all-lines adjuster who is appointed and employed by an insurer's affiliate may serve as a company employee adjuster for the purpose of ascertaining and determining the amount of an insurance claim, loss, or damage, or settling such claim, loss or damage.

Florida's Rating Law

Hurricane Model Averaging and Weighting

Section 6 amends s. 627.062, F.S., to provide that a residential property insurer's rate filing may estimate projected hurricane losses by using a weighted or straight average of two or more methods or models approved by the Commission on Hurricane Loss Projection Methodology.

Residential Property Insurance Mitigation Credits, Discounts, or Other Rate Differentials

Section 7 amends. s. 627.0629, F.S., to provide that an insurer may file with the Office of Insurance Regulation a personal lines residential rating plan that provides premium discounts, credits, and other rate differentials based on windstorm construction standards developed by an independent, not-for-profit, scientific research organization, if such standards meet statutory requirements.

Required Notifications of Automatic Bank Withdrawals

Section 8 amends s. 627.0065, F.S., governing automatic bank withdrawals agreements between insurers and policyholders, to limit the requirement that an insurer must provide a policyholder 15 days advance written notice of any increase in policy premiums. Instead, notice will only be required for premium increases that will result in an increase of the automatic withdrawal of more than $10 from the previous withdrawal amount.

Citizens Eligibility for Commercial Residential Wind-Only Coverage

Section 9 amends s. 627.351, F.S., governing Citizens, to provide that condominium associations where 50 percent or more of the condominium units are rented more than eight times per year for a period of less than 30 days may be eligible for wind-only Citizens policies.

Delivery of Policies and Claims Communications

Section 10 amends s. 627.421, F.S., to eliminate a requirement that an insurer that provides electronic delivery of the insurance policy to a policyholder (or the person entitled to delivery) must also provide within the electronic transmission notice of the policyholder's right to receive the policy via United States mail. The section also deletes a requirement that the insurer provide a paper copy of the policy to the insured upon his or her request. For personal lines policies, an insurer may offer electronic delivery to the policyholder, but electronic delivery may only be used if the policyholder elects to receive electronic delivery of the policy. For commercial lines, the insurer may use electronic delivery without the consent of the policyholder unless the policyholder communicates to the insurer that he or she does not agree to electronic delivery.

Affirmative Exclusions of Property Insurance Deductibles and Coverages

Section 11 amends s. 627.701, F.S., governing hurricane deductibles in residential property insurance policies, to allow a policyholder to type the required statement[101] which the policyholder must complete and sign in order to select a hurricane deductible greater than 10 percent of the policy dwelling limits on a risk valued at less than $500,000.

Section 12 amends 627.712, F.S., governing windstorm and contents coverage exclusions, to allow a policyholder to affirmatively reject windstorm coverage under a residential property insurance policy by typing the required statement[102] which excludes coverage.

The bill also, the bill allows a policyholder, except for a condominium unit owner policy or tenant policy, to affirmatively reject contents coverage under a residential property insurance policy by typing the required statement[103] which excludes coverage.

The bill retains current law in both of these statutory sections that allows the policyholder to write out the required statements required in these sections.

Notice of Claims Under Assignment Agreements

Section 13 amends s. 627.7152, F.S., governing residential property insurance and commercial property insurance assignment agreements. The bill adds the services of inspection and providing a scope of service to the list of services contemplated by the definition of "assignment agreement."

The bill also specifies that the notice of intent to initiate litigation that must be sent by an assignee to an insurer must be sent to the name and mailing address designated by the insurer in the policy forms if notice is sent by certified mail, return receipt requested, or to the e-mail address designated by the insurer in the policy forms if notice is sent by electronic delivery.

[101] "I do not want the insurance on my home to pay for the first (specify dollar value) of damage from hurricanes. I will may those costs. My insurance will not."
[102] "I do not want the insurance on my (home/mobile home/condominium unit) to pay for damage from windstorms. I will pay those costs. My insurance will not."
[103] "I do not want the insurance on my (home/mobile home) to pay for the costs to repair or replace any contents that are damaged. I will pay those costs. My insurance will not."

This section is effective upon becoming law.

Notice of Limited Coverage for Antique Vehicles

Section 14 amends s. 627.7276, F.S., to require that an automobile policy that does not provide coverage for bodily injury liability and property damage liability include notice accompanying the declarations page that the policy does not provide such coverages and does not comply with any financial responsibility laws. Such policies generally cover antique motor vehicles.

Agent Licensing

Motor Vehicle Service Agreements

Section 15 amends s. 634.171, F.S., to provide that a licensed personal lines or general lines agent is exempt from salesperson licensing requirements to solicit, negotiate, advertise, or sell motor vehicle service agreements.

Home Warranty Contracts

Section 16 amends s. 634.317, F.S., to provide that a licensed personal lines or general lines agent is exempt from salesperson licensing requirements to solicit, negotiate, advertise, or sell home warranty contracts.

Service Warranty Contracts

Section 17 amends s. 634.419, F.S., to provide that a licensed personal lines or general lines agent is exempt from salesperson licensing requirements to solicit, negotiate, advertise, or sell service warranty contracts.

Reenactments

Section 18 reenacts s. 624.424(10), F.S., related to insurer's annual statements, to incorporate amendments made to s. 215.555, F.S., which address collateral protection insurance coverage amounts.

This section is effective June 1, 2023.

Section 19 reenacts s. 627.351(6)(v), F.S., related to Citizens Property Insurance Corporation, to incorporate amendments made to s. 215.555, F.S., which address collateral protection insurance coverage amounts.

This section is effective June 1, 2023.

Section 20 reenacts s. 626.865(1)(e), F.S., related to company employee adjusters, to incorporate amendments made to s. 626.865, F.S., which address insurer affiliates.

Section 21 reenacts paragraph (1)(d) and subsection (2) of section 627.7153, F.S., which addresses policies restricting assignments of post-loss benefits under a property insurance policy, to incorporate amendments made to s. 627.7152, F.S., which address assignment agreements.

This section is effective upon becoming law.

Effective Date

Section 22 provides that except as otherwise expressly provided in this act, and except for this section, which takes effect upon this act become law, this act is effective July 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 215.555, 440.381, 624.423, 626.856, 627.062, 627.0629, 627.0665, 627.351, 627.421, 627.701, 627.712, 627.7152, 627.7276, 634.171, 634.317, 634.419, 624.424, 626.865, and 627.7153.

This bill creates section 624.46227 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.)

CS by Banking and Insurance on December 1, 2021:

The committee substitute:

- Excludes any instrument by which a licensed public adjust receives any compensation, payment, commission, fee, or other thing of value for providing public adjuster services from the definition of "assignment agreement."

B. Amendments:

None.

868608

LEGISLATIVE ACTION

Senate	.	House
Comm: RS	.	
12/01/2021	.	
	.	
	.	
	.	

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

Senate Amendment

Delete line 470
and insert:
mitigate against further damage to the property. The term does not include fees collected by a public adjuster as defined in s. 626.854(1).

951404

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
12/01/2021	.	
	.	
	.	
	.	

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

Senate Substitute for Amendment (868608)

Delete line 470

and insert:

mitigate against further damage to the property. The term does not include any instrument by which a licensed public adjuster as defined in s. 626.854(1) receives any compensation, payment, commission, fee, or other thing of value for providing services under such licensure.

By Senator Perry

8-00440C-22 2022468__

A bill to be entitled

An act relating to insurance; amending s. 215.555, F.S.; redefining the term "covered policy" under the Florida Hurricane Catastrophe Fund in relation to certain collateral protection insurance policies; amending s. 440.381, F.S.; revising the annual audit requirement for construction classes to apply to new and renewal policies having estimated annual premiums over a specified threshold; amending s. 624.423, F.S.; specifying when service of process is valid and binding upon insurers; creating s. 624.46227, F.S.; authorizing any association, trust, or pool created for the purpose of forming a risk management mechanism or providing self-insurance for a public entity to establish a quorum and conduct public business through communications media technology; amending s. 626.856, F.S.; revising the definition of the term "company employee adjuster"; amending s. 627.062, F.S.; authorizing the use of a certain modeling indication for residential property insurance rate filings; amending s. 627.0629, F.S.; authorizing insurers to file certain insurance rating plans based on certain windstorm mitigation construction standards, if certain requirements are met; amending s. 627.0665, F.S.; revising notification requirements for insurers who have automatic bank withdrawal agreements with insureds to include notices when withdrawal amounts increase above a specified threshold; amending s. 627.351, F.S.; revising conditions for determining the

8-00440C-22 2022468__

ineligibility of condominiums for wind-only coverage; amending s. 627.421, F.S.; deleting a requirement for electronic transmissions of certain documents to include specified notices; deleting a requirement that paper copies of policies be provided upon request; amending ss. 627.701 and 627.712, F.S.; revising policyholder acknowledgment statement requirements for property insurance policies having certain hurricane deductibles or windstorm or contents coverage exclusions, respectively; amending s. 627.7152, F.S.; revising the definition of the term "assignment agreement"; specifying the addresses to which a notice of intent must be served; amending s. 627.7276, F.S.; revising notice requirements for motor vehicle policies that do not provide coverage for bodily injury and property damage liability; amending ss. 634.171, 634.317, and 634.419, F.S.; authorizing licensed personal lines or general lines agents to solicit, negotiate, advertise, or sell motor vehicle service agreements, home warranty contracts, and service warranty contracts, respectively, without a sales representative license; making technical changes; reenacting ss. 624.424(10) and 627.351(6)(v), F.S., relating to annual statements and other information and Citizens Property Insurance Corporation, respectively, to incorporate the amendment made to s. 215.555, F.S., in references thereto; reenacting s. 626.865(1)(e), F.S., relating to public adjuster's qualifications, to incorporate

the amendment made to s. 626.856, F.S., in a reference thereto; reenacting s. 627.7153(1) and (2)(d), F.S., relating to policies restricting assignment of post-loss benefits under a property insurance policy, to incorporate the amendment made to s. 627.7152, F.S., in references thereto; providing effective dates.

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

Section 1. Effective June 1, 2023, paragraph (c) of subsection (2) of section 215.555, Florida Statutes, is amended to read:

215.555 Florida Hurricane Catastrophe Fund.—

(2) DEFINITIONS.—As used in this section:

(c) "Covered policy" means any insurance policy covering residential property in this state, including, but not limited to, any homeowner, mobile home owner, farm owner, condominium association, condominium unit owner, tenant, or apartment building policy, or any other policy covering a residential structure or its contents issued by any authorized insurer, including a commercial self-insurance fund holding a certificate of authority issued by the Office of Insurance Regulation under s. 624.462, the Citizens Property Insurance Corporation, and any joint underwriting association or similar entity created under law. The term ~~"covered policy"~~ includes any collateral protection insurance policy covering personal residences which protects both the borrower's and the lender's financial interests, in an amount at least equal to the coverage amount for the dwelling in place under the lapsed homeowner's policy,

the coverage amount that the homeowner has been notified of by the collateral protection insurer, or the coverage amount the homeowner requests from the collateral protection insurer, if such collateral protection insurance policy can be accurately reported as required in subsection (5). Additionally, covered policies include policies covering the peril of wind removed from the Florida Residential Property and Casualty Joint Underwriting Association or from the Citizens Property Insurance Corporation, created under s. 627.351(6), or from the Florida Windstorm Underwriting Association, created under s. 627.351(2), by an authorized insurer under the terms and conditions of an executed assumption agreement between the authorized insurer and such association or Citizens Property Insurance Corporation. Each assumption agreement between the association and such authorized insurer or Citizens Property Insurance Corporation must be approved by the Office of Insurance Regulation before the effective date of the assumption, and the Office of Insurance Regulation must provide written notification to the board within 15 working days after such approval. "Covered policy" does not include any policy that excludes wind coverage or hurricane coverage or any reinsurance agreement and does not include any policy otherwise meeting this definition which is issued by a surplus lines insurer or a reinsurer. All commercial residential excess policies and all deductible buy-back policies that, based on sound actuarial principles, require individual ratemaking must ~~shall~~ be excluded by rule if the actuarial soundness of the fund is not jeopardized. For this purpose, the term "excess policy" means a policy that provides insurance protection for large commercial property risks and that provides

a layer of coverage above a primary layer insured by another insurer.

Section 2. Subsection (3) of section 440.381, Florida Statutes, is amended to read:

440.381 Application for coverage; reporting payroll; payroll audit procedures; penalties.—

(3) The Financial Services Commission, in consultation with the department, shall establish by rule minimum requirements for audits of payroll and classifications ~~in order~~ to ensure that the appropriate premium is charged for workers' compensation coverage. The rules must ~~shall~~ ensure that audits performed by both carriers and employers are adequate to provide that all sources of payments to employees, subcontractors, and independent contractors are ~~have been~~ reviewed and that the accuracy of classification of employees is ~~has been~~ verified. The rules must require ~~shall provide~~ that employers in all classes other than the construction class be audited at least ~~not less frequently than~~ biennially and may provide for more frequent audits of employers in specified classifications based on factors such as amount of premium, type of business, loss ratios, or other relevant factors. ~~In no event shall~~ Employers in the construction class~~,~~ generating more than the amount of premium required to be experience rated~~,~~ must be audited at least ~~less than~~ annually. The annual audits required for construction classes must ~~shall~~ consist of physical onsite audits for new and renewal policies only if the estimated annual premium is $10,000 or more. Payroll verification audit rules must include, but need not be limited to, the use of state and federal reports of employee income, payroll and other accounting

records, certificates of insurance maintained by subcontractors, and duties of employees. At the completion of an audit, the employer or officer of the corporation and the auditor must print and sign their names on the audit document and attach proof of identification to the audit document.

Section 3. Effective upon this act becoming a law, subsection (3) of section 624.423, Florida Statutes, is amended to read:

624.423 Serving process.—

(3) Service of process is valid and binding upon the insurer on the date process served upon the Chief Financial Officer is delivered to the insurer ~~and sent~~ or the date on which the insurer is notified that such information has been made available on a secured network in accordance with this section and s. 624.307(9) ~~shall for all purposes constitute valid and binding service thereof upon the insurer~~.

Section 4. Section 624.46227, Florida Statutes, is created to read:

624.46227 Meeting requirements.—Any association, trust, or pool authorized by state law and created for the purpose of forming a risk management mechanism or providing self-insurance for public entities in this state may establish a quorum and conduct public business through communications media technology.

Section 5. Section 626.856, Florida Statutes, is amended to read:

626.856 "Company employee adjuster" defined.—A "company employee adjuster" means a person licensed as an all-lines adjuster who is appointed and employed on an insurer's staff of adjusters, by an affiliate, or by a wholly owned subsidiary of

the insurer, and who undertakes on behalf of such insurer or other insurers under common control or ownership to ascertain and determine the amount of any claim, loss, or damage payable under a contract of insurance, or undertakes to effect settlement of such claim, loss, or damage.

Section 6. Paragraph (j) 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:

(j) With respect to residential property insurance rate filings, the rate filing:

1. Must account for mitigation measures undertaken by policyholders to reduce hurricane losses.

2. May use a modeling indication that is the weighted or straight average of two or more models found by the commission to be accurate or reliable pursuant to s. 627.0628.

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

Section 7. Subsection (9) is added to section 627.0629, Florida Statutes, to read:

627.0629 Residential property insurance; rate filings.—

(9) An insurer may file with the office a personal lines residential property insurance rating plan that provides justified premium discounts, credits, or other rate differentials based on windstorm mitigation construction standards developed by an independent, not-for-profit scientific research organization, if such standards meet the requirements

of this section.

Section 8. Section 627.0665, Florida Statutes, is amended to read:

627.0665 Automatic bank withdrawal agreements; notification required.—Any insurer licensed to issue insurance in this ~~the~~ state who has an automatic bank withdrawal agreement with an insured party for the payment of insurance premiums for any type of insurance shall give the named insured at least 15 days advance written notice of any increase in policy premiums that results in the next automatic bank withdrawal being increased by more than $10. Such notice must be provided before ~~prior to~~ any automatic bank withdrawal containing the ~~of an~~ increased premium amount.

Section 9. Paragraph (a) of subsection (6) of section 627.351, Florida Statutes, is amended to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(a) The public purpose of this subsection is to ensure that there is an orderly market for property insurance for residents and businesses of this state.

1. The Legislature finds that private insurers are unwilling or unable to provide affordable property insurance coverage in this state to the extent sought and needed. The absence of affordable property insurance threatens the public health, safety, and welfare and likewise threatens the economic health of the state. The state therefore has a compelling public interest and a public purpose to assist in assuring that property in this ~~the~~ state is insured and that it is insured at affordable rates so as to facilitate the remediation,

reconstruction, and replacement of damaged or destroyed property in order to reduce or avoid the negative effects otherwise resulting to the public health, safety, and welfare, to the economy of the state, and to the revenues of the state and local governments which are needed to provide for the public welfare. It is necessary, therefore, to provide affordable property insurance to applicants who are in good faith entitled to procure insurance through the voluntary market but are unable to do so. The Legislature intends, therefore, that affordable property insurance be provided and that it continue to be provided, as long as necessary, through Citizens Property Insurance Corporation, a government entity that is an integral part of the state, and that is not a private insurance company. To that end, the corporation shall strive to increase the availability of affordable property insurance in this state, while achieving efficiencies and economies, and while providing service to policyholders, applicants, and agents which is no less than the quality generally provided in the voluntary market, for the achievement of the foregoing public purposes. Because it is essential for this government entity to have the maximum financial resources to pay claims following a catastrophic hurricane, it is the intent of the Legislature that the corporation continue to be an integral part of the state and that the income of the corporation be exempt from federal income taxation and that interest on the debt obligations issued by the corporation be exempt from federal income taxation.

2. The Residential Property and Casualty Joint Underwriting Association originally created by this statute shall be known as the Citizens Property Insurance Corporation. The corporation

shall provide insurance for residential and commercial property, for applicants who are entitled, but, in good faith, are unable to procure insurance through the voluntary market. The corporation shall operate pursuant to a plan of operation approved by order of the Financial Services Commission. The plan is subject to continuous review by the commission. The commission may, by order, withdraw approval of all or part of a plan if the commission determines that conditions have changed since approval was granted and that the purposes of the plan require changes in the plan. For the purposes of this subsection, residential coverage includes both personal lines residential coverage, which consists of the type of coverage provided by homeowner, mobile home owner, dwelling, tenant, condominium unit owner, and similar policies; and commercial lines residential coverage, which consists of the type of coverage provided by condominium association, apartment building, and similar policies.

3. With respect to coverage for personal lines residential structures:

a. Effective January 1, 2014, a structure that has a dwelling replacement cost of $1 million or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $1 million or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2013, may continue to be covered by the corporation until the end of the policy term. The office shall approve the method used by the corporation for valuing the dwelling replacement cost for the purposes of this subparagraph. If a policyholder is insured by the corporation before being

determined to be ineligible pursuant to this subparagraph and such policyholder files a lawsuit challenging the determination, the policyholder may remain insured by the corporation until the conclusion of the litigation.

b. Effective January 1, 2015, a structure that has a dwelling replacement cost of $900,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $900,000 or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2014, may continue to be covered by the corporation only until the end of the policy term.

c. Effective January 1, 2016, a structure that has a dwelling replacement cost of $800,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $800,000 or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2015, may continue to be covered by the corporation until the end of the policy term.

d. Effective January 1, 2017, a structure that has a dwelling replacement cost of $700,000 or more, or a single condominium unit that has a combined dwelling and contents replacement cost of $700,000 or more, is not eligible for coverage by the corporation. Such dwellings insured by the corporation on December 31, 2016, may continue to be covered by the corporation until the end of the policy term.

The requirements of sub-subparagraphs b.-d. do not apply in counties where the office determines there is not a reasonable degree of competition. In such counties a personal lines

residential structure that has a dwelling replacement cost of less than $1 million, or a single condominium unit that has a combined dwelling and contents replacement cost of less than $1 million, is eligible for coverage by the corporation.

4. It is the intent of the Legislature that policyholders, applicants, and agents of the corporation receive service and treatment of the highest possible level but never less than that generally provided in the voluntary market. It is also intended that the corporation be held to service standards no less than those applied to insurers in the voluntary market by the office with respect to responsiveness, timeliness, customer courtesy, and overall dealings with policyholders, applicants, or agents of the corporation.

5.a. Effective January 1, 2009, a personal lines residential structure that is located in the "wind-borne debris region," as defined in s. 1609.2, International Building Code (2006), and that has an insured value on the structure of $750,000 or more is not eligible for coverage by the corporation unless the structure has opening protections as required under the Florida Building Code for a newly constructed residential structure in that area. A residential structure is deemed to comply with this sub-subparagraph if it has shutters or opening protections on all openings and if such opening protections complied with the Florida Building Code at the time they were installed.

b. Any major structure, as defined in s. 161.54(6)(a), that is newly constructed, or rebuilt, repaired, restored, or remodeled to increase the total square footage of finished area by more than 25 percent, pursuant to a permit applied for after

July 1, 2015, is not eligible for coverage by the corporation if the structure is seaward of the coastal construction control line established pursuant to s. 161.053 or is within the Coastal Barrier Resources System as designated by 16 U.S.C. ss. 3501-3510.

6. With respect to wind-only coverage for commercial lines residential condominiums, ~~effective July 1, 2014,~~ a condominium may ~~shall~~ be deemed ineligible for coverage when ~~if~~ 50 percent or more of the units are rented more than eight times in a calendar year for a rental agreement period of less than 30 days.

Section 10. 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 communicates to the insurer in writing or electronically that he or she does not agree to delivery by electronic means. ~~Electronic transmission shall include a notice to the insured or to the person entitled to delivery of a policy of his or her right to receive the policy via United States mail rather than via electronic transmission. A paper copy of the policy shall be provided to the insured or to the person entitled to delivery at his or her request.~~

Section 11. Paragraph (d) of subsection (4) of section 627.701, Florida Statutes, is amended to read:

627.701 Liability of insureds; coinsurance; deductibles.—

(4)

(d)1. A personal lines residential property insurance policy covering a risk valued at less than $500,000 may not have a hurricane deductible in excess of 10 percent of the policy dwelling limits, unless the following conditions are met:

a. The policyholder must personally write or type and provide to the insurer the following statement ~~in his or her own handwriting~~ and sign his or her name, which must also be signed by every other named insured on the policy, and dated: "I do not want the insurance on my home to pay for the first (specify dollar value) of damage from hurricanes. I will pay those costs. My insurance will not."

b. If the structure insured by the policy is subject to a mortgage or lien, the policyholder must provide the insurer with a written statement from the mortgageholder or lienholder

indicating that the mortgageholder or lienholder approves the policyholder electing to have the specified deductible.

2. A deductible subject to the requirements of this paragraph applies for the term of the policy and for each renewal thereafter. Changes to the deductible percentage may be implemented only as of the date of renewal.

3. An insurer shall keep the original copy of the signed statement required by this paragraph, electronically or otherwise, and provide a copy to the policyholder providing the signed statement. A signed statement meeting the requirements of this paragraph creates a presumption that there was an informed, knowing election of coverage.

4. The commission shall adopt rules providing appropriate alternative methods for providing the statements required by this section for policyholders who have a handicapping or disabling condition that prevents them from providing a handwritten statement.

Section 12. Paragraph (a) of subsection (2) and subsection (3) of section 627.712, Florida Statutes, are amended to read:

627.712 Residential windstorm coverage required; availability of exclusions for windstorm or contents.—

(2) A property insurer must make available, at the option of the policyholder, an exclusion of windstorm coverage.

(a) The coverage may be excluded only if:

1. When the policyholder is a natural person, the policyholder personally writes or types and provides to the insurer the following statement ~~in his or her own handwriting~~ and signs his or her name, which must also be signed by every other named insured on the policy, and dated: "I do not want the

insurance on my (home/mobile home/condominium unit) to pay for damage from windstorms. I will pay those costs. My insurance will not."

2. When the policyholder is other than a natural person, the policyholder provides to the insurer on the policyholder's letterhead the following statement that must be signed by the policyholder's authorized representative and dated: "...(Name of entity)... does not want the insurance on its ...(type of structure)... to pay for damage from windstorms. ...(Name of entity)... will be responsible for these costs. ...(Name of entity's)... insurance will not."

(3) An insurer issuing a residential property insurance policy, except for a condominium unit owner policy or a tenant policy, must make available, at the option of the policyholder, an exclusion of coverage for the contents. The coverage may be excluded only if the policyholder personally writes or types and provides to the insurer the following statement ~~in his or her own handwriting~~ and signs his or her signature, which must also be signed by every other named insured on the policy, and dated: "I do not want the insurance on my (home/mobile home) to pay for the costs to repair or replace any contents that are damaged. I will pay those costs. My insurance will not."

Section 13. Effective upon this act becoming a law, paragraph (b) of subsection (1) and paragraph (a) of subsection (9) of section 627.7152, Florida Statutes, are amended to read:

627.7152 Assignment agreements.—

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

(b) "Assignment agreement" means any instrument by which post-loss benefits under a residential property insurance policy

or commercial property insurance policy, as that term is defined in s. 627.0625(1), are assigned or transferred, or acquired in any manner, in whole or in part, to or from a person providing services, including, but not limited to, scopes of service, to inspect, protect, repair, restore, or replace property or to mitigate against further damage to the property.

(9)(a) An assignee must provide the named insured, insurer, and the assignor, if not the named insured, with a written notice of intent to initiate litigation before filing suit under the policy. Such notice must be served at least 10 business days before filing suit, but not before the insurer has made a determination of coverage under s. 627.70131, by certified mail, return receipt requested, to the name and mailing address designated by the insurer in the policy forms or by electronic delivery to the e-mail address designated by the insurer in the policy forms ~~at least 10 business days before filing suit, but may not be served before the insurer has made a determination of coverage under s. 627.70131~~. The notice must specify the damages in dispute, the amount claimed, and a presuit settlement demand. Concurrent with the notice, and as a precondition to filing suit, the assignee must provide the named insured, insurer, and the assignor, if not the named insured, a detailed written invoice or estimate of services, including itemized information on equipment, materials, and supplies; the number of labor hours; and, in the case of work performed, proof that the work has been performed in accordance with accepted industry standards.

Section 14. Section 627.7276, Florida Statutes, is amended to read:

627.7276 Notice of limited coverage.—

(1) An automobile policy that does not contain coverage for bodily injury and property damage must include a notice ~~be clearly stamped or printed to the effect~~ that such coverage is not included in the policy in the following manner:

"THIS POLICY DOES NOT PROVIDE BODILY INJURY AND PROPERTY DAMAGE LIABILITY INSURANCE OR ANY OTHER COVERAGE FOR WHICH A SPECIFIC PREMIUM CHARGE IS NOT MADE, AND DOES NOT COMPLY WITH ANY FINANCIAL RESPONSIBILITY LAW."

(2) This notice ~~legend~~ must accompany ~~appear on~~ the policy declarations ~~declaration~~ page and ~~on the filing back of the policy and~~ be ~~printed~~ in a ~~contrasting color from that used on the policy and in~~ type size ~~larger than the largest type used in the text~~ at least as large as the type size used on the declarations page ~~thereof, as an overprint or by a rubber stamp impression~~.

Section 15. Section 634.171, Florida Statutes, is amended to read:

634.171 Salesperson to be licensed and appointed; exemptions.—Salespersons for motor vehicle service agreement companies and insurers must ~~shall~~ be licensed, appointed, renewed, continued, reinstated, or terminated as prescribed in chapter 626 for insurance representatives in general. However, they are ~~shall be~~ exempt from all other provisions of chapter 626, including those relating to fingerprinting, photo identification, education, and examination ~~provisions~~.

Applicable license, appointment, and other fees are as ~~shall be~~ ~~those~~ prescribed in s. 624.501. A licensed and appointed salesperson is ~~shall be~~ directly responsible and accountable for all acts of her or his employees and other representatives. Each service agreement company or insurer shall, on forms prescribed by the department, within 30 days after termination of the appointment, notify the department of such termination. An ~~No~~ employee or a salesperson of a motor vehicle service agreement company or an insurer may not directly or indirectly solicit or negotiate insurance contracts, or hold herself or himself out in any manner to be an insurance agent, unless so qualified, licensed, and appointed therefor under the Florida Insurance Code. A licensed personal lines or general lines agent is not required to be licensed as a salesperson under this section to solicit, negotiate, advertise, or sell motor vehicle service agreements. A motor vehicle service agreement company is not required to be licensed as a salesperson to solicit, sell, issue, or otherwise transact the motor vehicle service agreements issued by the motor vehicle service agreement company.

Section 16. Section 634.317, Florida Statutes, is amended to read:

634.317 License and appointment required; exemptions.—A ~~No~~ person may not solicit, negotiate, or effectuate home warranty contracts for remuneration in this state unless such person is licensed and appointed as a sales representative. A licensed and appointed sales representative is ~~shall be~~ directly responsible and accountable for all acts of the licensee's employees. A licensed personal lines or general lines agent is not required

to be licensed as a sales representative under this section to solicit, negotiate, advertise, or sell home warranty contracts.

Section 17. Section 634.419, Florida Statutes, is amended to read:

634.419 License and appointment required; exemptions.—A ~~No~~ person or an entity may not ~~shall~~ solicit, negotiate, advertise, or effectuate service warranty contracts in this state unless such person or entity is licensed and appointed as a sales representative. Sales representatives are ~~shall be~~ responsible for the actions of persons under their supervision. However, a service warranty association licensed as such under this part is ~~shall~~ not ~~be~~ required to be licensed and appointed as a sales representative to solicit, negotiate, advertise, or effectuate its products. A licensed personal lines or general lines agent is not required to be licensed as a sales representative under this section to solicit, negotiate, advertise, or sell service warranty contracts.

Section 18. Effective June 1, 2023, for the purpose of incorporating the amendment made by this act to section 215.555, Florida Statutes, in a reference thereto, subsection (10) of section 624.424, Florida Statutes, is reenacted to read:

624.424 Annual statement and other information.—

(10) Each insurer or insurer group doing business in this state shall file on a quarterly basis in conjunction with financial reports required by paragraph (1)(a) a supplemental report on an individual and group basis on a form prescribed by the commission with information on personal lines and commercial lines residential property insurance policies in this state. The supplemental report shall include separate information for

personal lines property policies and for commercial lines property policies and totals for each item specified, including premiums written for each of the property lines of business as described in ss. 215.555(2)(c) and 627.351(6)(a). The report shall include the following information for each county on a monthly basis:

(a) Total number of policies in force at the end of each month.

(b) Total number of policies canceled.

(c) Total number of policies nonrenewed.

(d) Number of policies canceled due to hurricane risk.

(e) Number of policies nonrenewed due to hurricane risk.

(f) Number of new policies written.

(g) Total dollar value of structure exposure under policies that include wind coverage.

(h) Number of policies that exclude wind coverage.

Section 19. Effective June 1, 2023, for the purpose of incorporating the amendment made by this act to section 215.555, Florida Statutes, in a reference thereto, paragraph (v) of subsection (6) of section 627.351, Florida Statutes, is reenacted to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(v)1. Effective July 1, 2002, policies of the Residential Property and Casualty Joint Underwriting Association become policies of the corporation. All obligations, rights, assets and liabilities of the association, including bonds, note and debt obligations, and the financing documents pertaining to them become those of the corporation as of July 1, 2002. The

corporation is not required to issue endorsements or certificates of assumption to insureds during the remaining term of in-force transferred policies.

2. Effective July 1, 2002, policies of the Florida Windstorm Underwriting Association are transferred to the corporation and become policies of the corporation. All obligations, rights, assets, and liabilities of the association, including bonds, note and debt obligations, and the financing documents pertaining to them are transferred to and assumed by the corporation on July 1, 2002. The corporation is not required to issue endorsements or certificates of assumption to insureds during the remaining term of in-force transferred policies.

3. The Florida Windstorm Underwriting Association and the Residential Property and Casualty Joint Underwriting Association shall take all actions necessary to further evidence the transfers and provide the documents and instruments of further assurance as may reasonably be requested by the corporation for that purpose. The corporation shall execute assumptions and instruments as the trustees or other parties to the financing documents of the Florida Windstorm Underwriting Association or the Residential Property and Casualty Joint Underwriting Association may reasonably request to further evidence the transfers and assumptions, which transfers and assumptions, however, are effective on the date provided under this paragraph whether or not, and regardless of the date on which, the assumptions or instruments are executed by the corporation. Subject to the relevant financing documents pertaining to their outstanding bonds, notes, indebtedness, or other financing obligations, the moneys, investments, receivables, choses in

action, and other intangibles of the Florida Windstorm Underwriting Association shall be credited to the coastal account of the corporation, and those of the personal lines residential coverage account and the commercial lines residential coverage account of the Residential Property and Casualty Joint Underwriting Association shall be credited to the personal lines account and the commercial lines account, respectively, of the corporation.

4. Effective July 1, 2002, a new applicant for property insurance coverage who would otherwise have been eligible for coverage in the Florida Windstorm Underwriting Association is eligible for coverage from the corporation as provided in this subsection.

5. The transfer of all policies, obligations, rights, assets, and liabilities from the Florida Windstorm Underwriting Association to the corporation and the renaming of the Residential Property and Casualty Joint Underwriting Association as the corporation does not affect the coverage with respect to covered policies as defined in s. 215.555(2)(c) provided to these entities by the Florida Hurricane Catastrophe Fund. The coverage provided by the fund to the Florida Windstorm Underwriting Association based on its exposures as of June 30, 2002, and each June 30 thereafter shall be redesignated as coverage for the coastal account of the corporation. Notwithstanding any other provision of law, the coverage provided by the fund to the Residential Property and Casualty Joint Underwriting Association based on its exposures as of June 30, 2002, and each June 30 thereafter shall be transferred to the personal lines account and the commercial lines account of

the corporation. Notwithstanding any other provision of law, the coastal account shall be treated, for all Florida Hurricane Catastrophe Fund purposes, as if it were a separate participating insurer with its own exposures, reimbursement premium, and loss reimbursement. Likewise, the personal lines and commercial lines accounts shall be viewed together, for all fund purposes, as if the two accounts were one and represent a single, separate participating insurer with its own exposures, reimbursement premium, and loss reimbursement. The coverage provided by the fund to the corporation shall constitute and operate as a full transfer of coverage from the Florida Windstorm Underwriting Association and Residential Property and Casualty Joint Underwriting Association to the corporation.

Section 20. For the purpose of incorporating the amendment made by this act to section 626.856, Florida Statutes, in a reference thereto, paragraph (e) of subsection (1) of section 626.865, Florida Statutes, is reenacted to read:

626.865 Public adjuster's qualifications, bond.—

(1) The department shall issue a license to an applicant for a public adjuster's license upon determining that the applicant has paid the applicable fees specified in s. 624.501 and possesses the following qualifications:

(e) Has been licensed in this state as an all-lines adjuster, and has been appointed on a continual basis for the previous 6 months as a public adjuster apprentice under s. 626.8561, as an independent adjuster under s. 626.855, or as a company employee adjuster under s. 626.856.

Section 21. Effective upon this act becoming a law, for the purpose of incorporating the amendment made by this act to

section 627.7152, Florida Statutes, in references thereto, subsection (1) and paragraph (d) of subsection (2) of section 627.7153, Florida Statutes, are reenacted to read:

627.7153 Policies restricting assignment of post-loss benefits under a property insurance policy.—

(1) As used in this section, the term "assignment agreement" has the same meaning as provided in s. 627.7152.

(2) An insurer may make available a policy that restricts in whole or in part an insured's right to execute an assignment agreement only if all of the following conditions are met:

(d) Each restricted policy include on its face the following notice in 18-point uppercase and boldfaced type:

THIS POLICY DOES NOT ALLOW THE UNRESTRICTED ASSIGNMENT OF POST-LOSS INSURANCE BENEFITS. BY SELECTING THIS POLICY, YOU WAIVE YOUR RIGHT TO FREELY ASSIGN OR TRANSFER THE POST-LOSS PROPERTY INSURANCE BENEFITS AVAILABLE UNDER THIS POLICY TO A THIRD PARTY OR TO OTHERWISE FREELY ENTER INTO AN ASSIGNMENT AGREEMENT AS THE TERM IS DEFINED IN SECTION 627.7152 OF THE FLORIDA STATUTES.

Section 22. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2022.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

December 1, 2021
Meeting Date

Banking and Insurance
Committee

SB 468
Bill Number or Topic

Amendment Barcode (if applicable)

Name Josh Aubuchon

Phone 583-2400

Address 201 E Park Ave, Suite 200B
Street

Email

Tallahassee FL 32301
City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
State Farm

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12-1-2021
Meeting Date

Banking & Insurance
Committee

468
Bill Number or Topic

Amendment Barcode (if applicable)

Name B.G. Murphy

Phone ~~850~~ 863-698-8870

Address
Street

Email bmurphy@faia.com

City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Association of Insurance Agents

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

12/01/21
Meeting Date

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

SB 468
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Candace Bunker

Phone (850) 513.5767

Address 2101 Maryland Circle
Street

Email candace.bunker@citizensfla.com

Tallahassee FL 32303
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Citizens Property Insurance Corporation

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/21
Meeting Date

B+I
Committee

468
Bill Number or Topic

Amendment Barcode (if applicable)

Name Scott Matiyow (MAT-E-O) Phone 850-597-7425

Address 215 S Monroe St suite 835 Email Scott.Matiyow@Pitt.org
Street

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/2021
Meeting Date

Banking & Insurance
Committee

SB 468
Bill Number or Topic

Amendment Barcode (if applicable)

Name Steve Cain

Phone 305-358-6644

Address One Southeast Third Avenue, Suite 3000
Street

Email scain@stfblaw.com

Miami | FL | 33131
City | *State* | *Zip*

Speaking: ☐ For ☑ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/2021
Meeting Date

Banking & Insurance
Committee

SB 468
Bill Number or Topic

Amendment Barcode (if applicable)

Name Molli McGuire

Phone 850-270-3406

Address 122 S. Calhoun St
Street

Email molli@mcguirelitigation.com

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

Committee Agenda Request

To: Senator Jim Boyd, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: October 21, 2021

I respectfully request that **Senate Bill #468**, relating to Insurance, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

W. Keith Perry

Senator Keith Perry
Florida Senate, District 8

File signed original with committee office

S-020 (03/2004)

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 546
INTRODUCER:	Senator Gruters
SUBJECT:	Consumer Finance Loans
DATE:	November 30, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Arnold	Knudson	BI	**Favorable**
2.			CM	
3.			RC	

I. Summary:

SB 546 makes several amendment to the Florida Consumer Finance Act in ch. 516, F.S. The bill:

- Expressly prohibits prepayment penalties for consumer finance loans;
- Authorizes an applicant for licensure or a licensee to provide a surety bond, certificate of deposit, or letter of credit in the amount of $25,000, in lieu of meeting the requirement to maintain $25,000 in liquid assets;
- Requires a company with at least one currently licensed location to provide a rider or surety bond of at least $5,000 for each additional license; however, the maximum aggregate requirement for such a company is $100,000; and
- Additional conforming changes.

The bill takes effect October 1, 2022.

II. Present Situation:

Consumer Finance Loans

The Office of Financial Regulation's (OFR) Division of Consumer Finance is responsible for the licensing and regulation of non-depository financial service entities and individuals, and conducts examinations and complaint investigations for licensed entities to determine compliance with Florida law.

Consumer finance loans are one of the loan products regulated by the OFR's Division of Consumer Finance through the Florida Consumer Finance Act, ch. 516, F.S. ("the Act"). A consumer finance loan" is a "loan of money, credit, goods, or choses in action,[1] including, except

[1] "Chose in action" is defined as "1. A property right in personam, such as a debt owed by another person . . . 2. The right to bring an action to recover a debt, money, or thing. 3. Personal property that one person owns but another person possesses, the owner being able to regain possession through a lawsuit." BLACK'S LAW DICTIONARY 101 (3d ed. 1996).

as otherwise specifically indicated, provision of a line of credit, in an amount or to a value of $25,000 or less for which the lender charges, contracts for, collects, or receives interest at a rate greater than 18 percent per annum."[2] Although consumer finance loans may be secured or unsecured, the Act prohibits lenders from taking a security interest in certain types of collateral.[3]

Consumer finance loans made pursuant to the Act must be repaid in periodic installments as nearly equal as mathematically practicable, except that the final payment may be less than the amount of the prior installments.[4] Installments may be due every two weeks, semimonthly, or monthly.[5] There is no minimum or maximum loan term under the Act.

Florida's prohibition on usury generally prohibits[6] interest rates in excess of 18 percent per annum simple interest on any loan, advance of money, line of credit, or forbearance.[7] Licensed consumer finance lenders, however, may offer interest rates greater than 18 percent per annum simple interest, up to the limits provided in ch. 516, F.S.[8] Consumer finance loans have a tiered interest rate structure such that the maximum annual interest rate allowed on each tier decreases as principle amounts increase:

- 30 percent on the first $3,000.
- 24 percent on principal above $3,000 and up to $4,000.
- 18 percent on principal above $4,000 and up to $25,000.[9]

The original principal amount is the amount financed, as defined by the federal Truth in Lending Act (TILA)[10] and TILA's federal implementing regulations.[11] For the purpose of determining compliance with these statutory maximum interest rates, the interest rate computations used must be simple interest.[12] In the event that two or more interest rates are applied to the principal amount of a loan,[13] a lender may charge interest at a single annual percentage rate (APR) which would produce at maturity the total amount of interest as permitted by the tiered interest rate structure above.[14] The APR charged by a lender may not exceed the APR that must be computed

[2] Section 516.01(2), F.S.
[3] *See* s. 516.031(1), F.S. (prohibition on taking a security interest in land for a loan less than $1,000); s. 516.17, F.S. (prohibition on assignment of, or order for payment of, wages given to secure a loan).
[4] S. 516.36, F.S. This section does not apply to lines of credit.
[5] *Id.*
[6] Various lenders and credits licensed or chartered under the laws of the United States or specified chapters of the Florida Statutes may charge interest at the maximum rate of interest permitted by law for similar loans or extensions of credit. See s. 687.12(1), F.S.
[7] Section 687.02, F.S
[8] Section 687.12, F.S.
[9] Section 516.031(1), F.S.
[10] Codified at 15 U.S.C. § 1601 *et seq.*
[11] Currently, the statute references TILA's implementing regulations as "Regulation Z of the Board of Governors of the Federal Reserve System." s. 516.031(1), F.S. However, the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, H.R. 4173, 124 Stat. 1376-2223, 111th Cong. (July 21, 2010), commonly referred to as the "Dodd-Frank Act", transferred rulemaking authority for TILA to the Bureau of Consumer Financial Protection, effective July 21, 2011. *See also* Truth in Lending (Regulation Z), 76 Fed. Reg. 79768 (Dec. 22, 2011).
[12] *Id.*
[13] For example, on a principle amount of $3,500, an interest rate of 30 percent per annum may be applied to $3,000 of the principle amount, and an interest rate of 24 percent per annum may be applied to the remaining $500 of the principal amount.
[14] Section 516.031(1), F.S.

and disclosed according to TILA and its implementing regulations.[15] A licensee may not induce or permit a borrower to divide a loan and may not induce or permit a person to become obligated to the licensee under more than one loan contract for the purpose of obtaining a greater finance charge than would otherwise be permitted under the parameters described above.[16]

If consideration for a new loan contract includes the unpaid principal balance of a prior loan with the licensee, then the principal amount of the new loan contract may not include more than 60 days' unpaid interest accrued on the prior loan.[17]

The Act prohibits lenders from directly or indirectly charging borrowers additional fees as a condition to the grant of a loan, except for the following allowable fees:

- Up to $25 for investigating the credit and character of the borrower;
- A $25 annual fee on the anniversary date of each line-of-credit account;
- Brokerage fees for certain loans, title insurance, and appraisals of real property offered as security;
- Intangible personal property tax on the loan note or obligation if secured by a lien on real property;
- Documentary excise tax and lawful fees for filing, recording, or releasing an instrument securing the loan;
- The premium for any insurance in lieu of perfecting a security interest otherwise required by the licensee in connection with the loan;
- Actual and reasonable attorney fees and court costs;
- Actual and commercially reasonable expenses for repossession, storing, repairing and placing in condition for sale, and selling of any property pledged as security;
- A delinquency charge of up to $15 for each payment in default for at least 10 days, if agreed upon in writing before the charge is imposed; and
- A bad check charge of up to $20.[18]

Because the above list of permissible fees does not include a prepayment penalty, then impliedly a licensee is prohibited from charging a prepayment penalty.[19]

Optional credit property, credit life, and disability insurance may be provided at the borrower's expense via a deduction from the principal amount of the loan.[20]

Licenses granted under the Act are for a single place of business[21] and must be renewed every two years.[22] As of February 16, 2021, there are 170 licensed consumer finance loan companies operating in Florida operating across a total of 382 locations.[23]

[15] Section 516.031(2), F.S.
[16] Section 516.031(4), F.S.
[17] Section 516.031(5), F.S.
[18] Section 516.031(3), F.S.
[19] *Id.*; Office of Financial Regulation, *Agency Analysis of 2021 House Bill 895, p. 2* (Feb. 17, 2021).
[20] Section 516.35(2), F.S.
[21] Sections 516.01(1) and 516.05(3), F.S.
[22] Sections 516.03(1) and 516.05(1) & (2), F.S.
[23] Office of Financial Regulation, *supra* note 16.

The yearly data for licensure under ch. 516, F.S., is contained in the charts below.[24]

Chapter 516, F.S., Licenses by Year										
	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08	08-09	09-10
Applications Received	318	44	136	82	48	72	192	30	52	32
Applications Approved	228	136	125	76	43	64	95	29	18	19
Active Licenses	589	607	568	609	532	584	626	600	390	386
Renewals & Reactivations	496	1	542	0	523	1	569	0	388	0

Chapter 516, F.S., Licenses by Year (Cont'd)										
	10-11	11-12	12-13	13-14	14-15	15-16	16-17	17-18	18-19	19-20
Applications Received	175	41	82	116	66	102	55	96	109	100
Applications Approved	137	37	53	113	37	81	36	83	104	98
Active Licenses	347	303	293	349	331	349	338	373	348	390
Renewals & Reactivations	226	0	258	0	312	0	326	0	342	0

An application to become a consumer finance lender must be accompanied by a nonrefundable application fee of $625 and a nonrefundable investigation fee of $200.[25] Licenses must be renewed biennially, at which time the licensee must pay a nonrefundable biennial license fee of $625.[26] At the time of application, the applicant must provide evidence of liquid assets of at least $25,000.[27] Failure to maintain liquid assets of at least $25,000 constitutes grounds for denial of license.[28] Each location of a consumer finance lender must be separately licensed.[29]

The Act does not apply to persons doing business under state or federal laws governing banks, savings banks, trust companies, building and loan associations, credit unions, or industrial loan and investment companies.[30]

Deferred Presentment Transactions (Payday Loans)

Deferred presentment transactions, commonly referred to as "payday loans", are another small-dollar loan product under the OFR's regulatory authority. These transactions are governed by ch. 560, F.S., part IV.

[24] Office of Financial Regulation, *Active Licenses*, https://www.flofr.com/sitePages/documents/finregstats.pdf (last visited November 4, 2021).
[25] Sections 516.03(1), F.S.
[26] *Id.*; s. 516.05(1), F.S.
[27] Section 516.03(1), F.S.
[28] Section 516.07(1), F.S.
[29] Section 516.05(3), F.S.
[30] Section 516.02(4), F.S.

A deferred presentment transaction means providing currency or a payment instrument in exchange for a drawer's (borrower's) check and agreeing to hold the check for a number of days until depositing, presenting, or redeeming the payment instrument.[31] The only persons who may engage in deferred presentment transactions are financial institutions as defined in s. 655.005, F.S.,[32] and money services business licensed under ch. 560, F.S., part II[33] or part III.[34]

There are two types of payday loan products permitted in Florida:

- *Deferred presentment transaction not repayable in installments*: The face amount of a check taken for deferred presentment may not exceed $500, exclusive of fees.[35] Fees may not exceed 10 percent of payment provided to the drawer plus a verification fee of up to $5.[36] The term of a deferred presentment agreement may not be less than seven days or greater than 31 days.[37]
- *Deferred presentment installment transaction*: A deferred presentment installment transaction is repayable in installments, has a term of 60 to 90 days, and may have an outstanding transaction balance (exclusive of fees) of up to $1,000.[38] The permissible fees are a verification fee of up to $5 and up to 8 percent of the outstanding transaction balance on a biweekly basis.[39] The installment periods must be 13 days to one calendar month, except that the first installment period may be longer than the remaining installment periods by not more than 15 days.[40] Prepayment penalties are prohibited.[41]

A deferred presentment provider may not enter into a deferred presentment transaction with a drawer who has an outstanding deferred presentment transaction with any provider or within 24 hours of the termination of a previous transaction.[42] In order to enforce this restriction, the OFR maintains a database against which a deferred presentment provider must verify each transaction before entering into the deferred presentment agreement.[43] A deferred presentment provider may

[31] Section 560.402(2) & (3), F.S.
[32] Section 655.005, F.S., defines a "financial institution" to mean a state or federal savings or thrift association, bank, savings back, trust company, international bank agency, international banking corporation, international branch, international representative office, international administrative office, international trust entity, international trust company representative office, qualified limited service affiliate, credit union, or an agreement corporation operating pursuant to s. 25 of the Federal Reserve Act, 12 U.S.C. ss. 601 *et seq*. or Edge Act corporation organized pursuant to s. 25(a) of the Federal Reserve Act, 12 U.S.C. ss. 611 *et seq*.
[33] Licensure as a money transmitter. A money transmitter is defined by s. 560.103(23), F.S., as a corporation, limited liability company, limited liability partnership, or foreign entity qualified to do business in this state which receives currency, monetary value, or payment instruments for the purpose of transmitting the same by any means, including transmission by wire, facsimile, electronic transfer, courier, the Internet, or through bill payment services or other businesses that facilitate such transfer within this country, or to or from this country. Money transmitters may engage in check cashing under ch. 560, F.S., part III.
[34] Licensure as a check casher. A check casher is defined by s. 560.103(6), F.S., as a person who sells currency in exchange for payment instruments received, except travelers checks.
[35] Section 560.404(5), F.S.
[36] Section 560.404(6), F.S.
[37] Section 560.404(8), F.S.
[38] Section 560.404(5) & (8), F.S.
[39] Section 560.404(6), F.S.
[40] Section 560.404(26), F.S.
[41] Section 560.404(6)(c), F.S.
[42] Section 560.404(19), F.S.
[43] Section 560.404(19)(a) & (23), F.S.

not engage in the rollover of a deferred presentment agreement and may not redeem, extend, or otherwise consolidate a deferred presentment agreement with the proceeds of another deferred presentment transaction made by it or an affiliate.[44]

If the drawer in a deferred presentment installment transaction informs the deferred presentment provider in writing or in person by noon of the business day before a scheduled payment that the drawer cannot pay in full the scheduled payment, the provider must give the drawer one opportunity to defer a scheduled payment for no additional fee or charge.[45] The deferred payment is due after the last scheduled installment payment, at an interval which is no shorter than the intervals between the originally scheduled payments.[46] Thus, for a deferred presentment installment transaction in which payments are due once every two weeks, the deferred payment would be due at least two weeks after the final installment payment is due.

A deferred presentment provider may not include in the agreement a hold harmless clause, a confession of judgment clause, an assignment of or order for payment of wages or other compensation for services, or a provision in which the drawer waives any claim or defense arising out of the agreement or any provision of ch. 560, F.S., part IV.[47] A deferred presentment provider must comply with state and federal disclosure requirements.[48]

III. Effect of Proposed Changes:

Section 1 amends s. 516.03, F.S., governing application fees, to make conforming changes which reflect consumer finance lender licensing requirements amended in s. 516.05(10), F.S.

Section 2 amends s. 516.031, F.S., governing finance charges and maximum rates on consumer finance loans, to expressly prohibit prepayment penalties. Florida law allows consumer finance lenders to charge certain fees, including up to $25 for investigating the credit and character of the borrower. Because the list of permissible fees does not include a prepayment penalty, then impliedly a licensee is prohibited from charging a prepayment penalty. The bill makes explicit the implied prohibition on prepayment penalties.

Section 3 adds subsection (10) to s. 516.05, F.S., governing consumer finance lender licenses, to provide the following alternatives to the $25,000 liquid asset requirement:

- A surety bond in the amount of at least $25,000 filed with the office;
- A certificate of deposit in the amount of at least $25,000 filed with the office and deposited in a financial institution as defined in s. 655.005(1)(i), F.S; or
- A letter of credit in the amount of at least $25,000 filed with the office.

The bill requires lenders with multiple locations to provide a surety bond or rider in the amount of at least $5,000 for each additional license. The total aggregate amount of a surety bond required for a lender with multiple locations may not exceed $100,000.

[44] Section 560.404(18), F.S.
[45] Section 560.404, F.S.
[46] *Id.*
[47] Section 560.404(10), F.S.
[48] Section 560.404(13) & (20), F.S.

The bill requires the surety bond, certificate of deposit, or letter of credit to be filed with the office, name the office as a beneficiary, and be payable on a pro rata basis. The surety bond, certificate of deposit, letter of credit may not be canceled without providing the office with 30 calendar days' notice. Following a licensee's cessation of licensed operation in the state, the surety bond, certificate of deposit, and letter of credit must remain in place for a period of 2 years.

The bill authorizes the Financial Services Commission to initiate rulemaking to adopt forms and procedures to implement the alternatives to the liquid asset requirement.

Section 4 amends s. 516.07, F.S., which provides grounds for denying a consumer finance lender license, to make conforming changes which reflect consumer finance loans licensing requirements amended in s. 516.05(10), F.S.

Section 5 amends s. 559.952, F.S. governing the Financial Technology Sandbox, to make conforming changes which reflect consumer finance lender licensing requirements amended in s. 516.05(10), F.S.

Section 6 provides an effective date of October 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 516.03, 516.031, 516.05, 516.07, and 559.952.

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 Gruters

23-00431-22 2022546__

A bill to be entitled

An act relating to consumer finance loans; amending s. 516.03, F.S.; authorizing an applicant for a license to make and collect loans under the Florida Consumer Finance Act to provide certain documents in lieu of evidence of liquid assets; amending s. 516.031, F.S.; prohibiting a person licensed to make and collect consumer finance loans from charging prepayment penalties for loans; amending s. 516.05, F.S.; authorizing a licensee or an applicant for a license to make and collect consumer finance loans to provide a surety bond, certificate of deposit, or letter of credit in lieu of evidence of liquid assets; providing requirements for such bonds, certificates of deposit, and letters of credit; providing rulemaking authority to the Financial Services Commission; amending s. 516.07, F.S.; modifying grounds for denial of license or disciplinary action for certain violations of the Florida Consumer Finance Act; amending s. 559.952, F.S.; revising exceptions for a licensee during the Financial Technology Sandbox period; providing an effective date.

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

Section 1. Subsection (1) of section 516.03, Florida Statutes, is amended to read:

516.03 Application for license; fees; etc.—

(1) APPLICATION.—Application for a license to make loans

23-00431-22 2022546__

under this chapter shall be in the form prescribed by rule of the commission. The commission may require each applicant to provide any information reasonably necessary to determine the applicant's eligibility for licensure. The applicant shall also provide information that the office requires concerning any officer, director, control person, member, partner, or joint venturer of the applicant or any person having the same or substantially similar status or performing substantially similar functions or concerning any individual who is the ultimate equitable owner of a 10-percent or greater interest in the applicant. The office may require information concerning any such applicant or person, including, but not limited to, his or her full name and any other names by which he or she may have been known, age, social security number, residential history, qualifications, educational and business history, and disciplinary and criminal history. The applicant must provide evidence of liquid assets of at least $25,000 or documents satisfying the requirements of s. 516.05(10). At the time of making such application the applicant shall pay to the office a nonrefundable biennial license fee of $625. Applications, except for applications to renew or reactivate a license, must also be accompanied by a nonrefundable investigation fee of $200. An application is considered received for purposes of s. 120.60 upon receipt of a completed application form as prescribed by commission rule, a nonrefundable application fee of $625, and any other fee prescribed by law. The commission may adopt rules requiring electronic submission of any form, document, or fee required by this act if such rules reasonably accommodate technological or financial hardship. The commission may

prescribe by rule requirements and procedures for obtaining an exemption due to a technological or financial hardship.

Section 2. Subsection (6) is added to section 516.031, Florida Statutes, to read:

516.031 Finance charge; maximum rates.—

(6) PREPAYMENT PENALTIES PROHIBITED.—A licensee may not require a borrower to pay a prepayment penalty for paying all or part of the loan principal before the date on which the payment is due.

Section 3. Subsection (10) is added to section 516.05, Florida Statutes, to read:

516.05 License.—

(10)(a) In lieu of the $25,000 liquid asset requirement in s. 516.03(1), a licensee or an applicant may provide to the office:

1.a. A surety bond in the amount of at least $25,000, issued by a bonding company or an insurance company authorized to do business in this state.

b. A company with at least one currently licensed location must provide to the office a rider or surety bond in the amount of at least $5,000 for each additional license, issued by a bonding company or an insurance company authorized to do business in this state. However, the aggregate amount of the surety bond required for a company with multiple licenses may not exceed $100,000.

2. Evidence of a certificate of deposit in the amount of at least $25,000. The certificate of deposit must be deposited in a financial institution as defined in s. 655.005(1)(i).

3. An irrevocable letter of credit in the amount of at

least $25,000.

(b) The original surety bond, certificate of deposit, or letter of credit must be filed with the office, and the office must be named as beneficiary. The surety bond, certificate of deposit, or letter of credit must be for the use and benefit of any borrower who is injured by acts of a licensee involving fraud, misrepresentation, or deceit, including willful imposition of illegal or excessive charges, or misrepresentation, circumvention, or concealment of any matter required to be stated or furnished to a borrower, where such acts are in connection with a loan made under this chapter. The office, or any claimant, may bring an action in a court of competent jurisdiction on the surety bond, certificate of deposit, or letter of credit. The surety bond, certificate of deposit, or letter of credit must be payable on a pro rata basis, but the aggregate amount may not exceed the amount of the surety bond, certificate of deposit, or letter of credit.

(c) The surety bond, certificate of deposit, or letter of credit may not be canceled by the licensee, bonding or insurance company, or financial institution except upon notice to the office by certified mail. A cancellation may not take effect until 30 calendar days after receipt by the office of the written notice.

(d) The bonding or insurance company or financial institution must, within 10 calendar days after it pays a claim, give written notice to the office by certified mail of such payment, with details sufficient to identify the claimant and the claim or judgment paid.

(e) If the principal sum of the surety bond, certificate of

deposit, or letter of credit is reduced by one or more recoveries or payments, the licensee must furnish to the office a new or additional surety bond, certificate of deposit, or letter of credit so that the total or aggregate principal sum equals the amount required under this subsection. Alternatively, a licensee may furnish an endorsement executed by the bonding or insurance company or financial institution reinstating the required principal amount.

(f) The required surety bond, certificate of deposit, or letter of credit must remain in place for 2 years after the licensee ceases licensed operations in this state. During the 2-year period, the office may allow for a reduction or elimination of the surety bond, certificate of deposit, or letter of credit to the extent the licensee's outstanding consumer finance loans in this state are reduced.

(g) The commission may prescribe by rule forms and procedures to implement this subsection.

Section 4. Paragraph (b) of subsection (1) of section 516.07, Florida Statutes, is amended to read:

516.07 Grounds for denial of license or for disciplinary action.—

(1) The following acts are violations of this chapter and constitute grounds for denial of an application for a license to make consumer finance loans and grounds for any of the disciplinary actions specified in subsection (2):

(b) Failure to maintain liquid assets of at least $25,000 or a surety bond, certificate of deposit, or letter of credit in the amount required by s. 516.05(10) at all times for the operation of business at a licensed location or proposed

location.

Section 5. Paragraph (a) of subsection (4) of section 559.952, Florida Statutes, is amended to read:

559.952 Financial Technology Sandbox.—

(4) EXCEPTIONS TO GENERAL LAW AND WAIVERS OF RULE REQUIREMENTS.—

(a) Notwithstanding any other law, upon approval of a Financial Technology Sandbox application, the following provisions and corresponding rule requirements are not applicable to the licensee during the sandbox period:

1. Section 516.03(1), except for the application fee, the investigation fee, the requirement to provide the social security numbers of control persons, evidence of liquid assets of at least $25,000 or documents satisfying the requirements of s. 516.05(10), and the office's authority to investigate the applicant's background. The office may prorate the license renewal fee for an extension granted under subsection (7).

2. Section 516.05(1) and (2), except that the office shall investigate the applicant's background.

3. Section 560.109, only to the extent that the section requires the office to examine a licensee at least once every 5 years.

4. Section 560.118(2).

5. Section 560.125(1), only to the extent that the subsection would prohibit a licensee from engaging in the business of a money transmitter or payment instrument seller during the sandbox period.

6. Section 560.125(2), only to the extent that the subsection would prohibit a licensee from appointing an

authorized vendor during the sandbox period. Any authorized vendor of such a licensee during the sandbox period remains liable to the holder or remitter.

7. Section 560.128.

8. Section 560.141, except for s. 560.141(1)(a)1., 3., 7.-10. and (b), (c), and (d).

9. Section 560.142(1) and (2), except that the office may prorate, but may not entirely eliminate, the license renewal fees in s. 560.143 for an extension granted under subsection (7).

10. Section 560.143(2), only to the extent necessary for proration of the renewal fee under subparagraph 9.

11. Section 560.204(1), only to the extent that the subsection would prohibit a licensee from engaging in, or advertising that it engages in, the selling or issuing of payment instruments or in the activity of a money transmitter during the sandbox period.

12. Section 560.205(2).

13. Section 560.208(2).

14. Section 560.209, only to the extent that the office may modify, but may not entirely eliminate, the net worth, corporate surety bond, and collateral deposit amounts required under that section. The modified amounts must be in such lower amounts that the office determines to be commensurate with the factors under paragraph (5)(c) and the maximum number of consumers authorized to receive the financial product or service under this section.

Section 6. This act shall take effect October 1, 2022.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/01/2021
Meeting Date

Banking and Insurance
Committee

546
Bill Number or Topic

Consumer Finance Loans
Amendment Barcode (if applicable)

Name Scott Jenkins

Phone 8506610829

Address 201 E. Park Ave. Ste 200B
Street

Email scott@dacfl.com

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Financial Services Assoc.

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

Committee Agenda Request

To: Senator Jim Boyd, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: November 16, 2021

I respectfully request that **Senate Bill #546**, relating to Consumer Finance Loans, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Please let me know if you have any questions.

Sincerely,

Joe Gruters

Cc: James Knudson, Staff Director
Lisa Johnson, Deputy Staff Director
Amaura Canty, Committee Administrative Assistance

File signed original with committee office

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 838
INTRODUCER:	Senator Wright
SUBJECT:	Fire Investigators
DATE:	November 30, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Arnold	Knudson	BI	**Favorable**
2.			CA	
3.			AP	

I. Summary:

SB 838 expands the definition of "firefighter" in s. 112.1816, F.S., related to cancer diagnoses for firefighters, to include "full-time, Florida-certified fire investigators. Upon diagnosis of one of the 21 specific cancers enumerated within s. 112.1816, F.S., the bill has the effect of making a fire investigator eligible for benefits under the statute. The benefits are an alternative to pursuing a workers' compensation claim, and entitle an eligible firefighter to a one-time cash payout of $25,000, upon the firefighter's initial diagnosis of cancer, and cancer treatment with the employer reimbursing the firefighter for any out-of-pocket deductible, copayment, or coinsurance costs related to the cancer treatment. Based on the conclusive presumption contained in the statute that the cancer or the resulting treatment of cancer occurred in-the-line-of duty, if a firefighter meets the retirement plan's definition of totally and permanently disabled due to the cancer or circumstances that arise out of the treatment of cancer, the fire investigator is eligible for enhanced disability benefits either under an employer-sponsored retirement plan or employer-sponsored disability retirement plan. Likewise, if the firefighter dies from the cancer or circumstances that arise from the cancer treatment, the death is conclusively presumed to be in-the-line-of-duty, resulting in a higher death benefit for the firefighter's beneficiaries.

The Department of Financial Services currently employs 104 fire investigators within the Division of Investigative and Forensic Services, 86 of which are Florida-certified fire investigators or are in the process of becoming certified. These fire investigators respond to fire scenes throughout the State of Florida, supporting local law enforcement, and spend an average of three hours per investigation on-site. These on-site audits and investigations typically occur the same day of the fire or within three days of the fire. As a result, fire investigators sustain significant exposure to hazardous vapors, gases, and particles that are known to contribute to chronic health conditions, including cancer, as these dangerous chemicals and carcinogens remain after the fire.

The bill takes effect July 1, 2022.

II. Present Situation:

Cancer Studies Regarding Firefighters

The incidence of cancer among firefighters appears to be higher on average than other occupations. Firefighters work in inherently dangerous situations on a daily basis. They are exposed to many different carcinogens, either inhaled or absorbed through the skin both on the scene and in the firehouse. Studies have been conducted at the state, national, and international level resulting in the identification of cancers found to be common among firefighters.[1] This information has been used to train and educate firefighters to reduce exposure to carcinogens resulting from firefighting activities.

In 2010, the National Institute for Occupational Safety and Health (NIOSH) initiated a study to evaluate the cancer risk of firefighters.[2] The study served to identify whether firefighters are at a higher risk of developing cancer related to exposure on the job. Researchers studied death related to cancer as well as specific types of cancers involved. Researchers took into consideration the types and number of fire runs, use of protective equipment, and diesel exhaust controls. The study spanned four years and the sample size included over 30,000 career firefighters serving in Chicago, Philadelphia, and San Francisco between 1950 and 2010.

According to the 2010 study, firefighters have a nine percent higher risk of being diagnosed with cancer and a 14 percent higher risk of dying from cancer than the general population in the United States. The cancers mostly responsible for this higher risk were respiratory (lung, mesothelioma), gastrointestinal (oral cavity, esophageal, large intestine) and kidney.[3]

Recent Florida Legislation

In 2019, the Legislature created s. 112.1816, F.S.,[4] to make firefighters who are diagnosed with certain cancers eligible to receive certain disability or death benefits. Specifically, in lieu of pursuing workers' compensation coverage, a firefighter is entitled to cancer treatment and one-time cash payout of $25,000, upon the firefighter's initial diagnosis of cancer. In order to be entitled to such benefits, the firefighter must:

- Be employed full-time as a firefighter;
- Be employed by the state, university, city, county, port authority, special district, or fire control district;
- Have been employed by his or her employer for at least five continuous years;
- Not have used tobacco products for at least the preceding five years; and

---

[1] Occupation and Cancer, American Cancer Society, *available at* https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/occupation-and-cancer-fact-sheet.pdf; 15 Jobs That Put You at a Higher Risk of Cancer, *available at* https://www.cheatsheet.com/money-career/jobs-put-higher-cancer-risk.html/?a=viewall; Cancer Facts and Figures, American Cancer Society, *available at* https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures.html.
[2] *See* Exposure–response relationships for select cancer and non-cancer health outcomes in a cohort of US firefighters from San Francisco, Chicago and Philadelphia (1950–2009), *available at* https://www.cdc.gov/niosh/firefighters/pdfs/Daniels-et-al-(2015)-508.pdf.
[3] *Id*.
[4] Chapter 2019-21, L.O.F.

- Have not been employed in any other position in the preceding five years which is proven to create a higher risk for cancer.

Under the statute, the term "cancer" includes bladder cancer, brain cancer, breast cancer, cervical cancer, colon cancer, esophageal cancer, invasive skin cancer, kidney cancer, large intestinal cancer, lung cancer, malignant melanoma, mesothelioma, multiple myeloma, non-Hodgkin's lymphoma, oral cavity and pharynx cancer, ovarian cancer, prostate cancer, rectal cancer, stomach cancer, testicular cancer, and thyroid cancer.

The employer must provide coverage within an employer-sponsored health plan or through a group health insurance trust fund. The employer must timely reimburse the firefighter for any out-of-pocket deductible, co-payment, or coinsurance costs incurred due to the treatment of cancer.

For disability and death benefits, the employer must consider a firefighter permanently and totally disabled if the firefighter is diagnosed with one of the 21 enumerated cancers and meets the retirements plan's definition of totally and permanently disabled due to the diagnosis of cancer or circumstances that arise out of the treatment of cancer. Moreover, the cancer or the treatment of cancer is deemed to have occurred in the line of duty, resulting in higher disability and death benefits.

To cover the costs associated with changes to Florida Retirement System (FRS) benefits (disability retirement benefits and in-line-of-duty benefits), the statute provides adjustments to the employer-paid contribution rates for the Special Risk class and the Deferred Retirement Option Program (DROP) that fund the FRS's normal costs and unfunded actuarial liability, and adjusts the percentage of funds allocated to provide in line of duty death benefits for investment plan members.

To date, three cancer claims have been submitted under the statute, totaling $66,308 in payments.[5]

Section 112.1816, F.S., does not currently apply to full-time fire investigators.

Division of the State Fire Marshal

State law on fire prevention and control designates the Chief Financial Officer as the State Fire Marshal, operating through the Division.[6] Pursuant to this authority, the State Fire Marshal:

- Regulates, trains, and certifies fire service personnel;
- Investigates the causes of fires;
- Enforces arson laws;
- Regulates the installation of fire equipment;
- Conducts firesafety inspections of state property;
- Develops firesafety standards;

[5] Department of Financial Services, *Senate Bill 838 Agency Analysis* (November 19, 2021) (on file with the Senate Committee on Banking and Insurance).
[6] Section 633.104, F.S.

- Provides facilities for the analysis of fire debris; and
- Operates the Florida State Fire College.

The Division is comprised of two bureaus: the Bureau of Fire Prevention (BFP) and the Bureau of Fire Standards and Training (BFST).[7] The BFP conducts fire/life safety inspections and construction plans review on all state-owned buildings; regulates the fireworks and the fire sprinkler industries; inspects and licenses boilers; and certifies suppression industry workers.[8] The BFST approves firefighter training curricula; offers fire service training at the Florida State Fire College; and certifies that fire service members meet industry-based standards.[9]

Florida State Fire College

The Florida State Fire College, offers basic, intermediate, and advanced training and education courses, develops educational curricula to be used by other fire-rescue training agencies, and conducts research into new methods and technologies related to fire-rescue activities.[10] Course offerings fall into five general categories: academic, certification, certificate of competency, vocational, and non-credit.[11] The Fire Investigation is one such advanced training program.

Fire Investigator Program

The Fire Investigator Program is a voluntary, advanced training program administered by the Florida State Fire College and designed for certified firefighters, certified law enforcement officers, law enforcement crime scene technicians, and certified firesafety inspectors who have fire investigation responsibilities.[12]

The program offers Fire Investigator I and II Certifications of Competency. In the first, the individual must complete at least 360 hours of training, including courses in Fire Chemistry, Fire Origin and Cause, Fire Protection Systems, Building Construction, Latent Investigation, Arson Investigation, Post Blast Investigation, and Legal Issues for Fire Investigators.[13]

The Level II Certification of Competency is available to an individual holding a Fire Investigator II Certificate of Competency if the individual is also a certified firefighter, certified law enforcement officer, law enforcement crime scene technician, or certified sworn or non-sworn firesafety inspector, and has completed a Fire Investigator Portfolio and Fire Investigator Task Book.[14]

Since 2005, 1,740 individuals have been certified as Fire Investigators through the State Fire College.[15] Of these, 947 individuals hold both a Firefighter II and Fire Investigator certification,

[7] Department of Financial Services, Division of the State Fire Marshal, *What We Do*, https://www.myfloridacfo.com/division/sfm/ (last visited December 19, 2019).
[8] *Id.*
[9] *Id.*
[10] *See* Rule 69A-37.064, F.A.C.
[11] *Id*.
[12] *See* Rule 69A-37.065(3), F.A.C.
[13] *Id*.
[14] *Id.*
[15] Department of Financial Services, *Senate Bill 838 Agency Analysis* (November 19, 2021) (on file with the Senate Committee on Banking and Insurance).

and meet the criteria to be covered by the current definition of firefighter under s. 112.1816, F.S.[16]

The Department of Financial Services currently employs 104 fire investigators with the Division of Investigative and Forensic Services. Of these, 86 are Florida-certified or are in the process of earning certification.[17] These fire investigators respond to fire scenes throughout the State of Florida, supporting local law enforcement, and spend an average of three hours per investigation on-site. These on-site audits and investigations typically occur the same day of the fire or within three days of the fire. As a result, fire investigators sustain significant exposure to hazardous vapors, gases, and particles that are known to contribute to chronic health conditions, including cancer, as these dangerous chemicals and carcinogens remain after the fire.

III. Effect of Proposed Changes:

Section 1 amends s. 112.1816, F.S., related to cancer diagnoses for firefighters, to include a "full-time, Florida-certified fire investigator" in the current definition of "firefighter." The bill further adds "investigation of fires and explosives" to the list of primary responsibilities of an "employer" within the current definition of "firefighter."

Upon diagnosis of one of the 21 specific cancers enumerated within s. 112.1816, F.S., the bill has the effect of making a fire investigator eligible for benefits under the statute: (1) cancer treatment, at the employer's expense, and (2) a $25,000 cash payment. Under the bill, the fire investigator also becomes eligible for disability and death benefits. Based on the conclusive presumption contained in the statute that the cancer or the resulting treatment of cancer occurred in-the-line-of duty, and if the fire investigator meets the retirement plan's definition of totally and permanently disabled due to the diagnosis of cancer or circumstances that arise out of the treatment of cancer, the fire investigator becomes eligible for enhanced disability benefits either under an employer-sponsored retirement plan or employer-sponsored disability retirement plan. Likewise, if the fire investigator dies from the cancer or circumstances that arise from the cancer treatment, the fire investigator's death is conclusively presumed to be in-the-line-of-duty, resulting in a higher death benefit for the firefighter's beneficiaries.

Section 2 provides a legislative finding that determines that this act fulfills an important state interest.

Section 3 provides an effective date of July 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[16] *Id*.
[17] *Id*.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Indeterminate.

According to the Department of Financial Services:

> There are 1,740 individuals that have been certified as a Fire Investigator through the State Fire College since 2005. Of these 1,740, there are 947 that hold both a Firefighter II and Fire Investigator certification, and meet the criteria to be covered by the current definition of firefighter in s. 112.1816, F.S.
>
> The precise number of individual that are currently working as full-time fire investigators is unknown, as this is a one-time certification.
>
> Since the creation of s. 112.1816, F.S., in 2019, there have been 3 cancer claims reported totaling $66,308 in payments, a claims rate of less than 1 percent over the two-year period. It is anticipated that the addition of the Florida-certified fire investigators would only have a minimal fiscal impact on the Risk Management Trust Fund.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 112.1816 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 Wright

14-01027-22 2022838__

A bill to be entitled

An act relating to fire investigators; amending s. 112.1816, F.S.; revising the definition of the term "firefighter" to include full-time, Florida-certified fire investigators for the purpose of expanding eligibility for certain cancer treatment benefits to include such investigators; providing a declaration of important state interest; providing an effective date.

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

Section 1. Paragraph (c) of subsection (1) of section 112.1816, Florida Statutes, is amended to read:

112.1816 Firefighters; cancer diagnosis.—

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

(c) "Firefighter" means an individual employed as a full-time firefighter or full-time, Florida-certified fire investigator within the fire department or public safety department of an employer whose primary responsibilities are the prevention and extinguishing of fires; the investigation of fires and explosives; the protection of life and property; and the enforcement of municipal, county, and state fire prevention codes and laws pertaining to the prevention and control of fires.

Section 2. The Legislature determines and declares that this act fulfills an important state interest.

Section 3. This act shall take effect July 1, 2022.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to Senate professional staff conducting the meeting

Meeting Date: Banking / Insurance

Committee

838

Bill Number or Topic

Amendment Barcode (if applicable)

Name: Austin Stowers

Phone

Address

Street

Email

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: CFC State Fire Marshal

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by: Jimmy Patronis

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is [illegible]

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

DEC 01, 2021
Meeting Date

Banking & Insurance
Committee

SB 0838
Bill Number or Topic

Amendment Barcode (if applicable)

Name Chief Ray Colburn

Phone 407-468-6622

Address 221 Pinewood Dr
Street

Tallahassee FL 32303
City State Zip

Email rayatfca.org

Florida Fire Chiefs' Association

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/2021
Meeting Date

838
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Jeffrey Newsome, President Professional Firefighters of Palm Beach County Phone 561-969-0729

Address 3541 Old Lighthouse Cir Email president@iaff2928.com
Street

Wellington FL 33414
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

Department of Financial Services (DFS)
2022 Legislative Bill Analysis

BILL INFORMATION

Bill Number:	SB 838
Bill Title:	Fire Investigators
Bill Sponsor:	Wright
Effective Date:	7/1/22

ANALYSIS INFORMATION

Agency Contact:	Austin Stowers, Legislative Affairs Director, (850) 413-5939
Division Director:	Molly Merry
Program Analyst:	Robin Delaney
Analysis Date:	11/19/21

POLICY ANALYSIS

I. SUMMARY ANALYSIS

SB 838 revises the definition of firefighter in s. 112.1816, F.S., to include full-time, Florida-certified fire investigators. It also expands the definition of the responsibilities to include the investigation of fires and explosives.

II. PRESENT SITUATION

Presently, firefighter cancer benefits only apply to full-time firefighters and do not include Florida-certified fire investigators. The majority of firefighters covered by the Risk Management Trust Fund (RMTF) under s. 112.1816, F.S., are employees of the Department of Agriculture and Consumer Services. It is estimated there are 600-650 firefighters presently covered by the Risk Management Trust Fund (RMTF).

III. EFFECT OF PROPOSED CHANGES

This change will increase the number of employees eligible for firefighter cancer benefits under s. 112.1816, F.S. The Department of Financial Services is the only entity covered by the RMTF that employs Florida-certified fire investigators. DFS presently employs 104 fire investigators within the Division of Investigative and Forensic Services, 86 of which are Florida-certified fire investigators or are in the process of becoming certified. These investigators respond to fire scenes throughout the State of Florida, supporting local law enforcement and spending an average of 3 hours per investigation on-site. These on-site audits and investigations typically take place the same day of the fire or within three days of the fire. Investigators sustain significant exposure to hazardous vapors, gases and particles that are known to contribute to chronic health conditions including cancer, as these dangerous chemicals and carcinogens remain after the fire.

Since inception of SB 426 in 2019 there have been 3 cancer claims reported totaling $66,308 in payments, a claim rate of less than 1 percent over the two-year period. It is anticipated that the addition of the Florida-certified fire investigators would only have a minimal fiscal impact on the RMTF.

IV. DOES THE BILL DIRECT OR ALLOW THE DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? **Y☐ N☒**

If yes, explain:	
Is the change consistent with the agency's core mission?	**Y☐ N☐**
Rule(s) impacted (provide references to F.A.C.):	

V. DOES THE BILL REQUIRE REPORTS OR STUDIES? **Y☐ N☒**

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

VI. DOES THE BILL REQUIRE APPOINTMENTS OR MODIFY EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSIONS, ETC.? **Y☐ N☒**

Board:	
Board Purpose:	
Who Appoints:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

I. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? **Y☐ N☐**

Revenues:	
Expenditures:	There are 1740 individuals that have been certified as a Fire Investigator through the State Fire College since 2005. Of these 1740 individuals, there are 947 that hold both a Firefighter II and Fire Investigator certification, and meet the criteria to be covered by the current definition of firefighter in s. 112.1816, F.S. The precise number of individuals that are currently working as full-time fire investigator is unknown, as this is a one-time certification.

II. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y☒ N☐

Revenues:	
Expenditures:	The impact to the RMTF is minimal.
Does the legislation contain a State Government appropriation?	No.
If yes, was this appropriated last year?	

III. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y☐ N☒

Revenues:	
Expenditures:	
Other:	

IV. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y☐ N☒

If yes, explain impact.	
Bill Section Number:	

TECHNOLOGY IMPACT

I. DOES THE BILL IMPACT THE DEPARTMENT'S TECHNOLOGY SYSTEMS (I.E., IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y☐ N☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	

FEDERAL IMPACT

I. DOES THE BILL HAVE A FEDERAL IMPACT (I.E., FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y☐ N☒

If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	A. Does the proposed legislation conflict with existing federal law or regulations? If so, what laws and/or regulations? No. B. Does the proposed legislation raise significant constitutional concerns under the U.S. or Florida Constitutions (e.g. separation of powers, access to the courts, equal protection, free speech, establishment clause, impairment of contracts)? No. C. Is the proposed legislation likely to generate litigation and, if so, from what interest groups or parties? No. However, there is always a possibility of litigation in claims handling. The Department administers claims through the Division of Risk Management. D. Rules: The proposed legislation does not require the Department to promulgate, amend, or eliminate a rule.

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:	SPB 7016
INTRODUCER:	Banking and Insurance Committee
SUBJECT:	OGSR/Information Submitted by Insurers/Department of Financial Services
DATE:	December 2, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Arnold	Knudson		**BI Submitted as Comm. Bill/Fav**

I. Summary:

SPB 7016 continues the public records exemption for certain information submitted to the Department of Financial Services (DFS) related to an insurer's anti-fraud plan or annual fraud report pursuant to s. 626.9891, F.S., by removing the October 2, 2022, repeal date.

Currently, s. 626.9891, F.S., provides that certain information submitted to DFS related to an insurer's anti-fraud plan or annual fraud report is exempt from s. 119.07(1), F.S., and article I, section 24 of the Florida Constitution.

Pursuant to the Open Government Sunset Review (OGSR), the public records exemption is scheduled to repeal October 2, 2022, unless reenacted by the Legislature. Since the bill continues the exemption and does not expand the scope of the public records exemption, the bill requires a majority vote of each chamber for passage.

This bill takes effect October 1, 2022.

II. Present Situation:

Public Records Law

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] This applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

Chapter 119, F.S., known as the Public Records Act, constitutes the main body of public records laws.[3] The Public Records Act states that:

[1] FLA. CONST., art. I, s. 24(a).
[2] *Id*.
[3] Public records laws are found throughout the Florida Statutes.

> [i]t is the policy of this state that all state, county, and municipal records are open for personal inspection and copying by any person. Providing access to public records is a duty of each agency.[4]

The Public Records Act typically contains general exemptions that apply across agencies. Agency- or program-specific exemptions often are placed in the substantive statutes relating to that particular agency or program.

The Public Records Act does not apply to legislative or judicial records.[5] Legislative records are public pursuant to s. 11.0431, F.S. Public records exemptions for the Legislature are codified primarily in s. 11.0431(2)-(3), F.S., and adopted in the rules of each house of the legislature.

Section 119.011(12), F.S., defines "public records" to include:

> All documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connections with the transaction of official business by any agency.

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business which are used to "perpetuate, communicate, or formalize knowledge of some type."[6]

The Florida Statutes specify conditions under which public access to governmental records must be provided. The Public Records Act guarantees every person's right to inspect and copy any state or local government public record at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.[7] A violation of the Public Records Act may result in civil or criminal liability.[8]

Only the Legislature may create an exemption to public records requirements.[9] An exemption must be created by general law and must specifically state the public necessity justifying the exemption.[10] Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law. A bill enacting an exemption may not contain other substantive provisions[11] and must pass by a two-thirds vote of the members present and voting in each house of the Legislature.[12]

---

[4] Section 119.01(1), F.S.
[5] *Locke v. Hawkes*, 595 So. 2d 32, 34 (Fla. 1992); *see also Times Pub. Co. v. Ake*, 660 So. 2d 255 (Fla. 1995).
[6] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc. Inc*., 379 So. 2d 633, 640 (Fla. 1980).
[7] Section 119.07(1)(a), F.S.
[8] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[9] FLA. CONST., art. I, s. 24(c).
[10] *Id.*
[11] The bill may, however, contain multiple exemptions that relate to one subject.
[12] FLA. CONST., art. I, s. 24(c)

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." There is a difference between records the Legislature has determined to be exempt from the Public Records Act and those which the Legislature has determined to be exempt from the Public Records Act *and confidential*.[13] Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute.[14] Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances.[15]

Open Government Sunset Review Act

The provisions of s. 119.15, F.S., known as the Open Government Sunset Review Act (the Act), prescribe a legislative review process for newly created or substantially amended public records or open meetings exemptions,[16] with specified exceptions.[17] The Act requires the repeal of such exemption on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption or repeal the sunset date.[18] In practice, many exemptions are continued by repealing the sunset date, rather than reenacting the exemption.

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[19] An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- It allows the state or its political subdivision to effectively and efficiently administer a program, and administration would be significantly impaired without the exemption;[20]
- Releasing sensitive personal information would be defamatory or would jeopardize an individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[21] or
- It protects trade or business secrets.[22]

The Act also requires specified questions to be considered during the review process.[23] In examining an exemption, the Act directs the Legislature to question the purpose and necessity of reenacting the exemption.

---

[13] *WFTV, Inc. v. The Sch. Bd. of Seminole County*, 874 So. 2d 48, 53 (Fla. 5th DCA 2004).
[14] *Id.*
[15] *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991).
[16] Section 119.15, F.S. Section 119.15(4)(b), F.S., provides that an exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings.
[17] Section 119.15(2)(a) and (b), F.S., provides that exemptions required by federal law or applicable solely to the Legislature or the State Court System are not subject to the Open Government Sunset Review Act.
[18] Section 119.15(3), F.S.
[19] Section 119.15(6)(b), F.S.
[20] Section 119.15(6)(b)1., F.S.
[21] Section 119.15(6)(b)2., F.S.
[22] Section 119.15(6)(b)3., F.S.
[23] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?

If, in reenacting an exemption or repealing the sunset date, the exemption is expanded, then a public necessity statement and a two-thirds vote for passage are required.[24] If the exemption is reenacted or saved from repeal without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to expire, the previously exempt records will remain exempt unless otherwise provided by law.[25]

Insurer Anti-Fraud Investigative Units

Under Florida law, an admitted insurer is required to maintain a designated anti-fraud unit or division within its company, or contract with a third party, to investigate and report possible fraudulent insurance acts.[26] The insurer must also adopt an anti-fraud plan, file a description of the anti-fraud plan or copy of executed contract with the Department of Financial Services (DFS) Division of Investigative and Forensic Services (DIFS), and annually report data related to fraud for each line of business to DFS. The Financial Services Commission, DFS, and Office of Insurance Regulation may impose an administrative fine on a noncompliant insurer.

Each anti-fraud plan must include:
- An acknowledgment that the insurer has established procedures for detecting and investigating possible fraudulent insurance acts relating to the different types of insurance by that insurer;
- An acknowledgment that the insurer has established procedures for the mandatory reporting of possible fraudulent insurance acts to DIFS;
- An acknowledgment that the insurer provides the anti-fraud education and training required by this section to the anti-fraud investigative unit;
- A description of the required anti-fraud education and training;
- A description or chart of the insurer's anti-fraud investigative unit, including the position titles and descriptions of staffing; and
- The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit which may include objective criteria, such as the number of policies written, the number of claims received on an annual basis, the volume of suspected fraudulent claims detected on an annual basis, an assessment of the optimal caseload that one investigator can handle on an annual basis, and other factors.

Each insurer is required to report the following data related to fraud for each line of business:
- The number of policies in effect;
- The amount of premiums written for policies;
- The number of claims received;

- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[24] FLA. CONST. art. I, s. 24(c).
[25] Section 119.15(7), F.S.
[26] Section 626.9891, F.S.

- The number of claims referred to the anti-fraud investigative unit;
- The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;
- The number of claims investigated or accepted by the anti-fraud investigative unit;
- The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;
- The number of cases referred to DIFS;
- The number of cases referred to other law enforcement agencies;
- The number of cases referred to other entities; and
- The estimated dollar amount or range of damages on cases referred to DIFS or other agencies.

Section 626.9891(11), F.S., provides that certain information contained in an insurer's anti-fraud plan or annual fraud report submitted to DFS is exempt from s. 119.07(1) and article I, section 24 of the Florida Constitution. The following information covered by the public records exemption :

- A description of the required anti-fraud education and training;
- A description or chart of the insurer's anti-fraud investigative unit, including the position titles and descriptions of staffing;
- The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit which may include objective criteria, such as the number of policies written, the number of claims received on an annual basis, the volume of suspected fraudulent claims detected on an annual basis, an assessment of the optimal caseload that one investigator can handle on an annual basis, and other factors.
- The number of claims referred to the anti-fraud investigative unit;
- The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;
- The number of claims investigated or accepted by the anti-fraud investigative unit;
- The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related; and
- The estimated dollar amount or range of damages on cases referred to DIFS or other agencies.

Further, s. 626.9891(11), F.S., is subject to the Open Government Sunset Review Act and shall stand repealed on October 2, 2022, if not reenacted.

OGSR Survey and Results

In 2021, Senate professional staff sent out a survey to DFS to ascertain whether the public records exemption under s. 626.9891, F.S., remains necessary, pursuant to the OGSR Act.[27] DFS indicated information subject to the public records exemption under s. 626.9891, F.S. is not protected by another exemption or subject to multiple exemptions. DFS indicated there has been no litigation related to s. 626.9891, F.S.

[27] *See* DFS survey correspondence, dated November 23, 2021, on file with the Senate Committee on Banking and Insurance.

DFS recommends reenacting the public records exemption without changes. Further, DFS indicates this public records exemption is vital to prevent criminals from accessing such information to identify fraud prevention and detection strategies used by insurers, or to be alerted to potential or ongoing investigations. Such disclosure may assist criminals in impeding investigations or evading detection.

III. Effect of Proposed Changes:

Section 1 amends s. 626.9891, F.S., to continue the public records exemption related to insurer anti-fraud plans and annual fraud reports submitted to DFS.

Section 2 provides an effective date of October 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Vote Requirement

Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records requirements. This bill continues a current public records exemption beyond its current date of repeal; thus, the bill does not require an extraordinary vote for enactment.

Public Necessity Statement

Article I, s. 24(c) of the State Constitution requires a bill creating or expanding an exemption to the public records requirements to state with specificity the public necessity justifying the exemption. This bill continues a current public records exemption without expansion.

Breadth of Exemption

Article I, s. 24(c) of the State Constitution requires an exemption to the public records requirements to be no broader than necessary to accomplish the stated purpose of the law. The purpose of the law is to protect the disclosure of information that would assist perpetrators of insurance fraud in impeding investigations and evading detection. This bill exempts only information submitted by insurers to DFS related to anti-fraud plans and fraud reports from the public records requirements. The exemption does not appear to be broader than necessary to accomplish the purpose of the law.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 626.9891 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.

FOR CONSIDERATION By the Committee on Banking and Insurance

597-00969-22 20227016pb

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act; amending s. 626.9891, F.S., which provides an exemption from public records requirements for certain information submitted by insurers to the Department of Financial Services; removing the scheduled repeal of the exemption; providing an effective date.

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

Section 1. Section 626.9891, Florida Statutes, is amended to read:

626.9891 Insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance.—

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

(a) "Anti-fraud investigative unit" means the designated anti-fraud unit or division, or contractor authorized under subparagraph (2)(a)2.

(b) "Designated anti-fraud unit or division" includes a distinct unit or division or a unit or division made up of employees whose principal responsibilities are the investigation and disposition of claims who are also assigned investigation of fraud.

(2) By December 31, 2017, every insurer admitted to do business in this state shall:

(a)1. Establish and maintain a designated anti-fraud unit or division within the company to investigate and report possible fraudulent insurance acts by insureds or by persons

making claims for services or repairs against policies held by insureds; or

2. Contract with others to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

(b) Adopt an anti-fraud plan.

(c) Designate at least one employee with primary responsibility for implementing the requirements of this section.

(d) Electronically file with the Division of Investigative and Forensic Services of the department, and annually thereafter, a detailed description of the designated anti-fraud unit or division or a copy of the contract executed under subparagraph (a)2., as applicable, a copy of the anti-fraud plan, and the name of the employee designated under paragraph (c).

An insurer must include the additional cost incurred in creating a distinct unit or division, hiring additional employees, or contracting with another entity to fulfill the requirements of this section, as an administrative expense for ratemaking purposes.

(3) Each anti-fraud plan must include:

(a) An acknowledgment that the insurer has established procedures for detecting and investigating possible fraudulent insurance acts relating to the different types of insurance by that insurer;

(b) An acknowledgment that the insurer has established

procedures for the mandatory reporting of possible fraudulent insurance acts to the Division of Investigative and Forensic Services of the department;

(c) An acknowledgment that the insurer provides the anti-fraud education and training required by this section to the anti-fraud investigative unit;

(d) A description of the required anti-fraud education and training;

(e) A description or chart of the insurer's anti-fraud investigative unit, including the position titles and descriptions of staffing; and

(f) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit which may include objective criteria, such as the number of policies written, the number of claims received on an annual basis, the volume of suspected fraudulent claims detected on an annual basis, an assessment of the optimal caseload that one investigator can handle on an annual basis, and other factors.

(4) By December 31, 2018, each insurer shall provide staff of the anti-fraud investigative unit at least 2 hours of initial anti-fraud training that is designed to assist in identifying and evaluating instances of suspected fraudulent insurance acts in underwriting or claims activities. Annually thereafter, an insurer shall provide such employees a 1-hour course that addresses detection, referral, investigation, and reporting of possible fraudulent insurance acts for the types of insurance lines written by the insurer.

(5) Each insurer is required to report data related to fraud for each identified line of business written by the

insurer during the prior calendar year. The data shall be reported to the department by March 1, 2019, and annually thereafter, and must include, at a minimum:

(a) The number of policies in effect;

(b) The amount of premiums written for policies;

(c) The number of claims received;

(d) The number of claims referred to the anti-fraud investigative unit;

(e) The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;

(f) The number of claims investigated or accepted by the anti-fraud investigative unit;

(g) The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;

(h) The number of cases referred to the Division of Investigative and Forensic Services;

(i) The number of cases referred to other law enforcement agencies;

(j) The number of cases referred to other entities; and

(k) The estimated dollar amount or range of damages on cases referred to the Division of Investigative and Forensic Services or other agencies.

(6) In addition to providing information required under subsections (2), (4), and (5), each insurer writing workers' compensation insurance shall also report the following information to the department, on or before March 1, 2019, and annually thereafter:

(a) The estimated dollar amount of losses attributable to

workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

(b) The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

(c) The number of cases referred to the Division of Investigative and Forensic Services, delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

(7) An insurer who obtains a certificate of authority has 6 months in which to comply with subsection (2), and one calendar year thereafter, to comply with subsections (4), (5), and (6).

(8) If an insurer fails or otherwise refuses to comply with the provisions of this section, the department, office, or commission may:

(a) Impose an administrative fine of not more than $2,000 per day for such failure until the department, office, or commission deems the insurer to be in compliance;

(b) Impose an administrative fine for failure by an insurer to implement or follow the provisions of an anti-fraud plan or anti-fraud investigative unit description; or

(c) Impose the provisions of both paragraphs (a) and (b).

(9) On or before December 31, 2018, the Division of Investigative and Forensic Services shall create a report detailing best practices for the detection, investigation, prevention, and reporting of insurance fraud and other fraudulent insurance acts. The report must be updated as necessary but at least every 2 years. The report must provide:

(a) Information on the best practices for the establishment

of anti-fraud investigative units within insurers;

(b) Information on the best practices and methods for detecting and investigating insurance fraud and other fraudulent insurance acts;

(c) Information on appropriate anti-fraud education and training of insurer personnel;

(d) Information on the best practices for reporting insurance fraud and other fraudulent insurance acts to the Division of Investigative and Forensic Services and to other law enforcement agencies;

(e) Information regarding the appropriate level of staffing and resources for anti-fraud investigative units within insurers;

(f) Information detailing statistics and data relating to insurance fraud which insurers should maintain; and

(g) Other information as determined by the Division of Investigative and Forensic Services.

(10) The department may adopt rules to administer this section, except that it shall adopt rules to administer subsection (5).

(11)(a) The information submitted to the department pursuant to paragraphs (3)(d), (e), and (f) and paragraphs (5)(d), (e), (f), (g), and (k) is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(b) ~~This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.~~

~~(c)~~ This exemption applies to records held before, on, or

after the effective date of this act.

Section 2. This act shall take effect October 1, 2022.

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

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1/2021
Meeting Date

Banking & Insurance
Committee

7016
Bill Number or Topic

Amendment Barcode (if applicable)

Name Austin Stowers

Phone 850 413 5939

Address PL 22, The Capitol
Street

Email Austin.Stowers@myFloridaCFO.com

Tallahassee FL 32399
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Department of Financial Services

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

S-001 (08/10/2021)

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:	SPB 7018
INTRODUCER:	Banking and Insurance Committee
SUBJECT:	OGSR/Injured or Deceased Employee/Department of Financial Services
DATE:	December 2, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Schrader	Knudson		**BI Submitted as Comm. Bill/Fav**

I. Summary:

SB 7018 amends s. 440.1851, Florida Statutes (F.S.), to save from repeal a public records exemption relating to the personal identifying information of an injured or deceased worker contained in reports, notices, records, or supporting documentation held by the Department of Financial Services (DFS) pursuant to Florida's Workers' Compensation Law (ch. 440, F.S.). "Personal identifying information," means the injured or deceased employee's name, date of birth, home or mailing address, e-mail address, or telephone number. Section 440.1851, F.S., makes this information confidential and exempt and authorizes the DFS to disclose it only under certain specified conditions. The section also provides for criminal penalties for the willful and knowing unlawful disclosure of such information.

The bill takes effect October 1, 2022.

II. Present Situation:

Public Records Law

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] This applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

Chapter 119, F.S., known as the Public Records Act, constitutes the main body of public records laws.[3] The Public Records Act states that:

[1] FLA. CONST., art. I, s. 24(a).
[2] *Id*.
[3] Public records laws are found throughout the Florida Statutes.

> [i]t is the policy of this state that all state, county, and municipal records are open for personal inspection and copying by any person. Providing access to public records is a duty of each agency.[4]

The Public Records Act typically contains general exemptions that apply across agencies. Agency- or program-specific exemptions often are placed in the substantive statutes relating to that particular agency or program.

The Public Records Act does not apply to legislative or judicial records.[5] Legislative records are public pursuant to s. 11.0431, F.S. Public records exemptions for the Legislature are codified primarily in s. 11.0431(2)-(3), F.S., and adopted in the rules of each house of the legislature.

Section 119.011(12), F.S., defines "public records" to include:

> All documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connections with the transaction of official business by any agency.

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business which are used to "perpetuate, communicate, or formalize knowledge of some type."[6]

The Florida Statutes specify conditions under which public access to governmental records must be provided. The Public Records Act guarantees every person's right to inspect and copy any state or local government public record at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.[7] A violation of the Public Records Act may result in civil or criminal liability.[8]

Only the Legislature may create an exemption to public records requirements.[9] An exemption must be created by general law and must specifically state the public necessity justifying the exemption.[10] Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law. A bill enacting an exemption may not contain other substantive provisions[11] and must pass by a two-thirds vote of the members present and voting in each house of the Legislature.[12]

---

[4] Section 119.01(1), F.S.
[5] *Locke v. Hawkes*, 595 So. 2d 32, 34 (Fla. 1992); *see also Times Pub. Co. v. Ake*, 660 So. 2d 255 (Fla. 1995).
[6] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc. Inc*., 379 So. 2d 633, 640 (Fla. 1980).
[7] Section 119.07(1)(a), F.S.
[8] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[9] FLA. CONST., art. I, s. 24(c).
[10] *Id.*
[11] The bill may, however, contain multiple exemptions that relate to one subject.
[12] FLA. CONST., art. I, s. 24(c)

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." There is a difference between records the Legislature has determined to be exempt from the Public Records Act and those which the Legislature has determined to be exempt from the Public Records Act *and confidential*.[13] Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute.[14] Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances.[15]

Open Government Sunset Review Act

The provisions of s. 119.15, F.S., known as the Open Government Sunset Review Act (the Act), prescribe a legislative review process for newly created or substantially amended public records or open meetings exemptions,[16] with specified exceptions.[17] The Act requires the repeal of such exemption on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption or repeal the sunset date.[18] In practice, many exemptions are continued by repealing the sunset date, rather than reenacting the exemption.

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[19] An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- It allows the state or its political subdivision to effectively and efficiently administer a program, and administration would be significantly impaired without the exemption;[20]
- Releasing sensitive personal information would be defamatory or would jeopardize an individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[21] or
- It protects trade or business secrets.[22]

The Act also requires specified questions to be considered during the review process.[23] In examining an exemption, the Act directs the Legislature to question the purpose and necessity of reenacting the exemption.

---

[13] *WFTV, Inc. v. The Sch. Bd. of Seminole County*, 874 So. 2d 48, 53 (Fla. 5th DCA 2004).
[14] *Id.*
[15] *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991).
[16] Section 119.15, F.S. Section 119.15(4)(b), F.S., provides that an exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings.
[17] Section 119.15(2)(a) and (b), F.S., provides that exemptions required by federal law or applicable solely to the Legislature or the State Court System are not subject to the Open Government Sunset Review Act.
[18] Section 119.15(3), F.S.
[19] Section 119.15(6)(b), F.S.
[20] Section 119.15(6)(b)1., F.S.
[21] Section 119.15(6)(b)2., F.S.
[22] Section 119.15(6)(b)3., F.S.
[23] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?

If, in reenacting an exemption or repealing the sunset date, the exemption is expanded, then a public necessity statement and a two-thirds vote for passage are required.[24] If the exemption is reenacted or saved from repeal without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to expire, the previously exempt records will remain exempt unless otherwise provided by law.[25]

Department of Financial Services

The Chief Financial Officer is the head of the DFS.[26] Within the DFS's many divisions are the Division of Investigative and Forensic Services, the Division of Risk Management, and the Division of Workers' Compensation.

The Bureau of Insurance Fraud of the Division of Investigative and Forensic Services investigates alleged acts of insurance fraud not categorized under workers' compensation fraud, including: licensee, healthcare, application, vehicle, homeowners, commercial, disability, arson, and life insurance fraud. Within these categories are: organized schemes to defraud the public and insurers, insolvency of insurance companies due to internal fraud, criminal activity by unauthorized entities illegally doing business in Florida, and viatical related fraud.[27]

The Bureau of State Employee Workers' Compensation Claims, within the Division of Risk Management, is responsible for the administration of all workers' compensations claims filed by state employees and volunteers who are injured on the job. It typically receives approximately 12,000 new claims each year and is primarily responsible for ensuring that covered individuals receive timely benefits, while safeguarding the State from instances of fraud, waste, and abuse.[28]

The Division of Workers' Compensation is responsible for administering many of the provisions of ch. 440, F.S. In addition, the Agency for Health Care Administration and the Office of Judges of Compensation Claims within the Division of Administrative Hearings are also responsible for administering provisions of ch. 440, F.S., the Workers' Compensation Law.[29]

Section 440.185, F.S., establishes reporting requirements for employees, employers, and carriers relating to said employee suffering an injury arising out of and in the course of their employment. In particular, s. 440.185(2), F.S., requires that employers report such injury to its

- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[24] FLA. CONST. art. I, s. 24(c).
[25] Section 119.15(7), F.S.
[26] Section 20.121(1), F.S.
[27] Bureau of Insurance Fraud within the Division Investigative and Forensic Services, available at https://www.myfloridacfo.com/division/difs/insurance-fraud (last viewed Nov. 24, 2021).
[28] Bureau of State Employee Workers' Compensation Claims within the Division of Risk Management, available at https://www.myfloridacfo.com/division/risk/workers-compensation (last viewed Nov. 24, 2021).
[29] Sections 440.015, 440.135, 440.44, and 440.45, F.S.

workers' compensation insurance carrier, in a format prescribed by the department, and shall provide a copy of such report to the employee or the employee's estate.

- The name and address of the employer;
- The name, social security number, mailing address, telephone number, and occupation of the injured worker;
- The cause and nature of the injury or death;
- The year, month, day, and hour when, and the particular locality where the injury or death occurred; and
- Such other information the DFS may require.

Further, additional reports about the condition of the employee, including copies of medical reports and bills,[30] funeral expenses, and wage statements, must also be filed with the DFS.[31]

In addition to the First Report of Injury (form DFS-F2-DWC-1 as established by DFS), employers and carriers are also required to file subsequent reports with the DFS relating to an injured worker that contain information that would identify said worker.[32] These reports or forms include, but are not limited to, the following reports: Wage Statement, Request for Wage Loss/Temporary Partial Benefits, Notice of Action/Change, Notice of Denial, Claim Cost Report, Request for Social Security Disability Benefit Information, and Employee Earnings Report.[33]

Public Records Exemptions Relating to Florida's Workers' Compensation Law

Section 624.23, F.S., of the Florida Insurance Code provides a public record exemption for personal financial and health information[34] submitted by a consumer seeking assistance from the DFS. The term "consumer," as used in the section, means 1) a prospective purchaser, purchaser, or beneficiary of, or applicant for, any product or service regulated under the Florida Insurance Code, and a family member or dependent of said consumer, or 2) an employee seeking assistance from the Employee Assistance and Ombudsman Office under s. 440.191, F.S. This personal financial and health information held by the DFS or Office of Insurance Regulation, is confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

[30] Information in the medical reports may include the name and address of the injured worker, date of accident, and procedure and diagnosis code describing the treatment and nature of the injury. Section 440.13(4)(b), F.S., and Rules 69L-7.710-7.750, F.A.C.
[31] Section 440.185(4), F.S.
[32] *See* Division of Worker's Compensation Forms, available at https://www.myfloridacfo.com/division/wc/publicationsformsmanualsreports/forms/default.htm (last viewed Nov. 24, 2021).
[33] *Id.*
[34] Section 624.23, F.S., provides that a consumer's personal financial and health information means: Personal health condition, disease, or injury; a history of a consumer's personal medical diagnosis or treatment; the existence, nature, source, or amount of a consumer's personal income or expenses; records of or relating to a consumer's personal financial transactions of any kind; the existence, identification, nature, or value of a consumer's assets, liabilities, or net worth; the existence or content of, or any individual coverage or status under a consumer's beneficial interest in, any insurance policy or annuity contract; or the existence, identification, nature, or value of a consumer's interest in any insurance policy, annuity contract, or trust.

Further, s. 624.23(3), F.S., provides that this personal financial and health information may be disclosed to specified parties.[35]

Currently, ch. 440, F.S., provides three public records exemptions directly related to injured or deceased injured workers. The first exemption, s. 440.102(8), F.S., protects all information, interviews, reports, statements, memoranda, and drug test results, written or otherwise, received or produced because of a drug-testing program. The second exemption, s. 440.125, F.S., provides that medical records and medical reports identifying an injured worker, which are filed with the DFS pursuant to s. 440.13, F.S., are confidential and exempt.

The third exemption, s. 440.1851, F.S., is the subject of this open government sunset review. The exemption provides that personal identifying information of an injured or deceased worker contained in reports, notices, records, or supporting documentation held by the DFS pursuant to ch. 440, F.S. are confidential and exempt from public records requirements. As used in, s. 440.1851, F.S., "personal identifying information," means the injured or deceased employee's name, date of birth, home mailing, or e-mail address, or telephone number. Section 440.1851, F.S., provides that the DFS may only disclose such information:

- To the injured employee, to the spouse or a dependent of the deceased employee, to the spouse or a dependent of the injured employee if authorized by the injured employee, or to the legal representative of the deceased employee's estate;
- To a party litigant, or his or her authorized representative, in matters pending before the Office of the Judges of Compensation Claims;
- To a carrier or an employer for the purpose of investigating the compensability of a claim or for the purpose of administering its anti-fraud investigative unit established pursuant to s. 626.9891;
- In an aggregate reporting format that does not reveal the personal identifying information of any employee;
- Pursuant to a court order or subpoena;
- To an agency for administering its anti-fraud investigative function or in the furtherance of the agency's official duties and responsibilities; or
- To a federal governmental entity in the furtherance of the entity's official duties and responsibilities.

Section 440.1851, F.S., also provides for criminal penalties for the unlawful disclosure of the personal identifying information protected under the statute. Specifically, s. 440.1851(2), F.S., provides that a person willingly and knowingly disclosing such information commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, F.S.

Section 440.1851, F.S., was originally passed and signed into law in 2017. Pursuant to the Act, the section is set to stand repealed on October 2, 2022, unless saved from repeal through reenactment.

[35] The parties to whom disclosure may be made are: Another governmental entity, if disclosure is necessary for the receiving entity to perform its duties and responsibilities; the National Association of Insurance Commissioners; or the consumer or the legally authorized representative of the consumer.

Senate Banking and Insurance Committee staff surveyed the DFS to ascertain whether the public records exemption in s. 440.1851, F.S., remains necessary. Staff reviewed the DFS's responses to the questions to be considered by the Legislature in accordance with s. 119.115(6)(a), F.S. The DFS recommends that the Legislature reenact this public records exemption without revision. The DFS stated that, prior to the enactment of this exemption, the Division of Workers' Compensation received approximately 90 public records requests per month for the names and contact information of injured workers that were reported to the Division in the previous month. On average, about 4,750 injured workers' names were released each time one of these requests were fulfilled by the Division. According to the DFS, the majority of the requesting parties were law firms seeking to market their services to injured workers. The Division would regularly receive communications from injured workers complaining about the solicitations they were receiving and to ascertain how these firms acquired said workers' personal information. In addition, according to the DFS, background check companies would utilize this information provide their clients with knowledge on whether prospective new hires had sustained a workers' compensation injury and those clients subsequently potentially using such information to make determinations on employment.[36]

In addition, the DFS stated that it believes that s. 440.1851, F.S., mitigates unnecessary litigation between injured workers and carriers on claim disputes. The DFS admits that "it is impossible to definitively quantify the results," but cites as evidence of the mitigating effect that the number of Petitions for Benefits (PFB) filed with the Office of the Judges of Compensations (OJCC) have only slightly increased since 2017, while, the actual number of "new cases" with PFBs have stayed the same, despite Florida experience significant job growth during this time.[37] Though the evidence cited by the DFS may be indicative of said mitigating effect, it is also possible that this outcome was driven, at least in part, by other factors.

III. Effect of Proposed Changes:

Section 1 amends s. 440.1851, F.S., to delete the scheduled repeal of the current public records exemption of personal identifying information of an injured or deceased employee which is contained in reports, notices, records, or supporting documentation held by the DFS pursuant to the Workers' Compensation Law (ch. 440, F.S.). "Personal identifying information," means the injured or deceased employee's name, date of birth, home mailing, or e-mail address, or telephone number. This information will continue to be confidential and exempt from public disclosure, subject to the disclosures permitted pursuant to s. 440.1851(1)(b), F.S.

Because the bill does not expand the public records exemption or the open meetings exemption, the bill does not require a two-thirds vote of each house in order to pass.

Section 2 provides that the bill takes effect October 1, 2022.

[36] Correspondence from the DFS (Sep. 24, 2021), on file with Senate Banking and Insurance Committee.
[37] *Id.*

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Vote Requirement

Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records requirements. This bill continues a current public records exemption beyond its current date of repeal; thus, the bill does not require an extraordinary vote for enactment.

Public Necessity Statement

Article I, s. 24(c) of the State Constitution requires a bill creating or expanding an exemption to the public records requirements to state with specificity the public necessity justifying the exemption. This bill continues a current public records exemption without expansion.

Breadth of Exemption

Article I, s. 24(c) of the State Constitution requires an exemption to the public records requirements to be no broader than necessary to accomplish the stated purpose of the law. The purpose of the law is to protect personal identifying information of injured or deceased employees held by the DFS. Specifically, the section seek to protect this information to protect such persons from unwanted solicitation relating to workers compensation claims and protect such workers from potential discrimination or social stigma relating to their injury or disability. This bill exempts only an injured or deceased person's name, date of birth, home address or mailing address, e-mail address, and telephone number from the public records requirements. Since these any of these pieces may potentially be used to "personally identify" an injured or deceased person, the exemption does not appear to be broader than necessary to accomplish the purpose of the law.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends s. 440.185 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.

FOR CONSIDERATION By the Committee on Banking and Insurance

597-00936-22 20227018pb

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act; amending s. 440.1851, F.S., which provides an exemption from public records requirements for the personal identifying information of an injured or deceased employee which is contained in reports, notices, records, or supporting documentation held by the Department of Financial Services pursuant to the Workers' Compensation Law; removing the scheduled repeal of the exemption; providing an effective date.

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

Section 1. Section 440.1851, Florida Statutes, is amended to read:

440.1851 Personal identifying information of an injured or deceased employee; public records exemption.—

(1) The personal identifying information of an injured or deceased employee which is contained in reports, notices, records, or supporting documentation held by the department pursuant to this chapter is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(a) As used in this section, the term "personal identifying information" means the injured or deceased employee's name, date of birth, home address or mailing address, e-mail address, or telephone number.

(b) The department may disclose information made confidential and exempt under this section only:

1. To the injured employee, to the spouse or a dependent of

the deceased employee, to the spouse or a dependent of the injured employee if authorized by the injured employee, or to the legal representative of the deceased employee's estate;

2. To a party litigant, or his or her authorized representative, in matters pending before the Office of the Judges of Compensation Claims;

3. To a carrier or an employer for the purpose of investigating the compensability of a claim or for the purpose of administering its anti-fraud investigative unit established pursuant to s. 626.9891;

4. In an aggregate reporting format that does not reveal the personal identifying information of any employee;

5. Pursuant to a court order or subpoena;

6. To an agency for administering its anti-fraud investigative function or in the furtherance of the agency's official duties and responsibilities; or

7. To a federal governmental entity in the furtherance of the entity's official duties and responsibilities.

A carrier, employer, agency, or governmental entity receiving personal identifying information from the department shall maintain the confidential and exempt status of the information.

(c) This public records exemption applies to personal identifying information held by the department before, on, or after the effective date of this exemption.

(2) A person who willfully and knowingly discloses personal identifying information made confidential and exempt under this section to an unauthorized person or entity commits a misdemeanor of the first degree, punishable as provided in s.

775.082 or s. 775.083.

~~(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.~~

Section 2. This act shall take effect October 1, 2022.

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

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

12/1
Meeting Date

Banking & Insurance
Committee

7018
Bill Number or Topic

Amendment Barcode (if applicable)

Name Austin Stowers

Phone 850 413 5939

Address PL 11, The Capitol
Street

Email Austin.Stowers@myFloridaCFO.com

Tallahassee FL 32399
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Department of Financial Services

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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

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:	SPB 7020
INTRODUCER:	Banking and Insurance Committee
SUBJECT:	OGSR/Office of Financial Regulation
DATE:	December 2, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson		**BI Submitted as Comm. Bill/Fav**

I. Summary:

SPB 7020 saves from repeal two public record exemptions. The first relates to international trust entities and qualified limited service affiliates, which are types of financial institutions, and the second public record exemption relates to financial institutions generally. The Office of Financial Regulation (OFR) regulates these entities.

The public records exemption for international trust entities and qualified limited service affiliates applies to:

- Any personal identifying information of the customers or prospective customers of an affiliated international trust entity that appears in the records of an international trust company representative office or a qualified limited service affiliate.
- Any personal identifying information of the customers or prospective customers of an affiliated international trust entity that appears in records relating to reports of examinations, operations, or condition, including working papers, of an international trust company representative office or a qualified limited service affiliate.
- Any portion of a list of names of the shareholders or members of an affiliated international trust entity or a qualified limited service affiliate.
- Information received by OFR from a person from another state or country or the federal government, which is otherwise confidential or exempt pursuant to the laws of that state or country or pursuant to federal law.

The public records exemption for financial institutions, generally, applies to:

- Certain information held by OFR relating to investigations, reports of examinations, operations, or condition, including working papers, prepared by, or for the use of, OFR, or any state or federal agency responsible for the regulation or supervision of financial institutions in this state.
- Any confidential information supplied to OFR or to employees of any financial institution by other state or federal governmental agencies.

The Open Government Sunset Review Act requires the Legislature to review each public record and each public meeting exemption five years after enactment. The exemptions contained in ss. 655.057, 66.401, and 663.540, F.S., are scheduled to repeal on October 2, 2022. This bill removes the scheduled repeal to continue the confidential and exempt status of the information.

The bill is not expected to impact state and local revenues and expenditures.

The bill takes effect October 1, 2022.

II. Present Situation:

Public Records Law

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business. This applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.

Chapter 119, F.S., known as the Public Records Act, constitutes the main body of public records laws. The Public Records Act states that:

> [i]t is the policy of this state that all state, county, and municipal records are open for personal inspection and copying by any person. Providing access to public records is a duty of each agency.

The Public Records Act typically contains general exemptions that apply across agencies. Agency- or program-specific exemptions often are placed in the substantive statutes relating to that particular agency or program.

The Public Records Act does not apply to legislative or judicial records. Legislative records are public pursuant to s. 11.0431, F.S. Public records exemptions for the Legislature are codified primarily in s. 11.0431(2)-(3), F.S., and adopted in the rules of each house of the legislature.

Section 119.011(12), F.S., defines "public records" to include:

> All documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connections with the transaction of official business by any agency.

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business, which are used to "perpetuate, communicate, or formalize knowledge of some type."

The Florida Statutes specify conditions under which public access to governmental records must be provided. The Public Records Act guarantees every person's right to inspect and copy any state or local government public record at any reasonable time, under reasonable conditions, and

under supervision by the custodian of the public record. A violation of the Public Records Act may result in civil or criminal liability.

Only the Legislature may create an exemption to public records requirements. An exemption must be created by general law and must specifically state the public necessity justifying the exemption. Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law. A bill enacting an exemption may not contain other substantive provisions and must pass by a two-thirds vote of the members present and voting in each house of the Legislature.

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." There is a difference between records the Legislature has determined to be exempt from the Public Records Act and those which the Legislature has determined to be exempt from the Public Records Act and confidential. Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute. Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances.

Open Government Sunset Review Act

The provisions of s. 119.15, F.S., known as the Open Government Sunset Review Act (the Act), prescribe a legislative review process for newly created or substantially amended public records or open meetings exemptions,[1] with specified exceptions.[2] The Act requires the repeal of such exemption on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption or repeal the sunset date.[3] In practice, many exemptions are continued by repealing the sunset date, rather than reenacting the exemption.

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[4] An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- It allows the state or its political subdivision to effectively and efficiently administer a program, and administration would be significantly impaired without the exemption;[5]
- Releasing sensitive personal information would be defamatory or would jeopardize an individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[6] or

[1] Section 119.15, F.S. Section 119.15(4)(b), F.S., provides that an exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings.
[2] Section 119.15(2)(a) and (b), F.S., provides that exemptions required by federal law or applicable solely to the Legislature or the State Court System are not subject to the Open Government Sunset Review Act.
[3] Section 119.15(3), F.S.
[4] Section 119.15(6)(b), F.S.
[5] Section 119.15(6)(b)1., F.S.
[6] Section 119.15(6)(b)2., F.S.

- It protects trade or business secrets.[7]

The Act also requires specified questions to be considered during the review process.[8] In examining an exemption, the Act directs the Legislature to question the purpose and necessity of reenacting the exemption.

If, in reenacting an exemption or repealing the sunset date, the exemption is expanded, then a public necessity statement and a two-thirds vote for passage are required.[9] If the exemption is reenacted or saved from repeal without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to expire, the previously exempt records will remain exempt unless otherwise provided by law.[10]

Office of Financial Regulation

The Office of Financial Regulation (OFR) regulates financial institutions,[11] finance companies, money services businesses, and the securities industry.[12] The OFR is responsible for the regulation of various entities that engage in financial institution business in Florida, in accordance with the financial institutions codes.[13] In 2017, the Legislature created two new types of financial institutions, an international trust entity and a qualified limited service affiliate within the regulatory framework of international banking.[14] In 2017, the Legislature also created two related public records exemptions in the international banking chapter,[15] and substantially revised the current exemption relating to financial institutions in s. 655.057, F.S.[16]

Public Records Exemption for Financial Institutions Generally

[7] Section 119.15(6)(b)3., F.S.
[8] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[9] FLA. CONST. art. I, s. 24(c).
[10] Section 119.15(7), F.S.
[11] Section 655.005(1)(i), F.S., provides that a financial institution means a state or federal savings or thrift association, bank, savings bank, trust company, international bank agency, international banking corporation, international branch, international representative office, international administrative office, international trust entity, international trust company representative office, qualified limited service affiliate, credit union, or an agreement corporation operating pursuant to s. 25 of the Federal Reserve Act, 12 U.S.C. ss. 601 et seq. or Edge Act corporation organized pursuant to s. 25(a) of the Federal Reserve Act, 12 U.S.C. ss. 611 et seq.
[12] Section 20.121(3)(a)2., F.S.
[13] Chs. 655, 657, 658, 660, 662, 663, 665, and 667, F.S.
[14] Ch. 2017-83, Laws of Fla.
[15] Parts III and IV of ch. 663, F.S.
[16] Ch. 2017-84, Laws of Fla.

In the course of conducting an examination or an investigation of a financial institution, OFR generates many documents of a sensitive nature, such as records related to an investigation and "reports of examinations,[17] conditions, or operations, which includes working papers."[18] In 2017, the Legislature amended s. 655.057, F.S., to specify that the exemptions are not only confidential and exempt from s. 119.071(1), F.S., but also exempt from Article I, section 24(a), of the Florida Constitution.[19]

Section 655.057(1), F.S., provides that "all records and information relating to an investigation by OFR are confidential and exempt from s. 119.07(1), F.S., and Article I, section 24(a), of the Florida Constitution until the investigation is completed or ceases to be active."[20] Even after the completion of an investigation or the investigation ceases to be active, portions of the covered documents remain confidential and exempt from public disclosure under s. 119.071(1), F.S., and Article I, section 24(a), of the Florida Constitution to the extent that the documents:

- Would jeopardize the integrity of another active investigation;
- Impair the safety and soundness of the financial institution;
- Reveal personal financial information or the identity of a confidential source;
- Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual; or
- Reveal investigative techniques or procedures.[21]

Pursuant to s. 655.057(2), F.S., reports of examinations, operations, or condition, including working papers are confidential and exempt from the public records disclosure requirements of s. 119.07(1), F.S., and Article I, section 24(a), of the Florida Constitution.[22] Such documents may only be released to specified parties under certain circumstances, but any such information or records obtained from OFR that is confidential must be maintained as confidential and exempt from s. 119.07(1), F.S., and Article I, section 24(a), of the Florida Constitution.[23] Although reports of examination are generally confidential and exempt from public disclosure, the statute provides that OFR must release reports of examination within 1 year after the appointment of a liquidator, receiver, or conservator to the financial institution.[24] However, any portion of such reports that discloses the identities of depositors, bondholders, members, borrowers, or stockholders, other than directors, officers, or controlling stockholders of the institution must be redacted by OFR because this information remains confidential and exempt from the public

[17] An "examination report" is any record "submitted to or prepared by OFR as part of its supervisory duties performed pursuant to s. 655.012, F.S., or its examination authority pursuant to s. 655.045(1), F.S. *See* Section 655.057(12)(a), F.S.
[18] Section 655.057(12), F.S., working papers include the records of the procedures followed, the tests performed , the information obtained, and the conclusions reached in an examination or investigation performed pursuant to s. 655.032 or s. 655.045, F.S.
[19] Subsections (1), (2), (5), and (9) of s. 655.057, F.S.
[20] Section 655.057(1), F.S.
[21] If an investigation relates to an informal enforcement action, once an investigation is completed or ceases to be active, the informal enforcement action is confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art, I, of the State Constitution to the extent that disclosure would jeopardize the integrity of another active investigation, impair the safety and soundness of the financial institution, reveal personal financial information or the identity of a confidential source, defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual, or reveal investigative techniques or procedures. *See* s. 655.057(12), F.S.
[22] Section 655.057(2), F.S.
[23] *Id*.
[24] Section 655.057(2)(g), F.S.

records disclosure requirements of s. 119.07(1), F.S., and Article I, section 24(a), of the Florida Constitution.[25]

Section 655.057(9), F.S., provides that any confidential documents supplied to OFR or to employees of any financial institution by other state or federal governmental agencies is confidential and exempt from s. 119.071(1), F.S., and Article I, section 24(a), of the Florida Constitution.[26]

Notwithstanding the above exemptions, s. 655.057(5), F.S., specifies information that may be provided to particular parties under certain circumstances. However, any such confidential information or records obtained from OFR must be maintained as confidential and exempt from s. 119.07(1), F.S., and Article I, section 24(a), of the Florida Constitution.[27]

Public Record Exemptions for an International Trust Entity and a Qualified Limited Service Affiliate

For purposes of parts III[28] and IV[29] of ch. 663, F.S., an international trust entity is an international trust company or organization, or any similar business entity, or an affiliated[30] or subsidiary entity that is licensed, chartered, or similarly permitted to conduct trust business in a foreign country or countries under the laws where such entity is organized and supervised.[31] Part IV defines a qualified limited service affiliate as a person or entity that is qualified under this part to perform the permissible activities outlined in s. 663.531, F.S., related to or for the benefit of an affiliated international trust entity.[32]

Section 663.416(2), F.S., provides that the following information held by OFR is confidential and exempt from s. 119.07(1), F.S., and Article I, section 24(a), of the Florida Constitution:

- Any personal identifying information of the customers or prospective customers of an affiliated international trust entity which appears in the books and records of an international trust company representative office (ITCRO)[33] or in records relating to reports of examinations, operations, or condition of an ITCRO, including working papers.
- Any portion of a list of names of the shareholders or members of an affiliated international trust entity.
- Information received by OFR from a person from another state or country or the Federal Government, which is otherwise confidential or exempt pursuant to the laws of that state or country or pursuant to federal law.[34]

[25] *Id.*
[26] Section 655.057(9), F.S.
[27] Section 655.057(5), F.S.
[28] Section 663.401(3), F.S.
[29] Section 663.401(2), F.S.
[30] Section 663.401, F.S., defines affiliate.
[31] Section 663.530(1)(c), F.S.
[32] Section 663.530(1)(f), F.S.
[33] An international trust company representative office is an office of an international trust entity which is established or maintained in this state for the purpose of engaging in nonfiduciary activities described in s. 663.409, F.S. or any affiliate, subsidiary, or other person that engages in such activities on behalf of such international trust entity from an office located in this state. *See* s. 663.401(2), F.S.
[34] Section 663.416(3), F.S., authorizes OFR to release certain confidential and exempt information to specified persons.

Section 663.540(2), F.S., provides that the following information is confidential and exempt from s. 119.07(1), F.S., and Article I, section 24(a), of the Florida Constitution:

- Any personal identifying information of the customers or prospective customers of an affiliated international trust entity which appears in the books and records of a qualified limited service affiliate or which appears in records relating to reports of examinations, operations, or condition, including working papers, of a qualified limited service affiliate papers.
- Any portion of a list of names of the shareholders or members of a qualified limited service affiliate.
- Information received by OFR from a person from another state or country or the Federal Government, which is otherwise confidential or exempt pursuant to the laws of that state or country or pursuant to federal law.[35]

Open Government Sunset Review Findings and Recommendations

In 2021, the Senate Banking and Insurance Committee staff sent an Open Government Sunset Review Survey to the Office of Financial Regulation regarding the public records exemptions that are subject to OGSR. In their response, OFR recommends that the exemption remain in effect to protect sensitive information related to examinations and investigations by OFR, personal financial information, and sensitive information that is shared with OFR by other governmental agencies which remains the property of those agencies.[36]

In regards to public records' request for OFR records exempted in sections 663.416 and 663.540, F.S., the OFR has not received any requests during the period of January 5, 2017 to July 23, 2021.[37] In regards to requests for public records regarding other financial institution records as described s. 655.057, F.S., OFR has received almost 200 requests for public records during the same period.[38]

III. Effect of Proposed Changes:

Section 1 amends s. 663.416, F.S, to save from repeal and reenact the current public records exemption relating to personal identifying information of the customers or prospective customers of an affiliated international trust entity, which appear in the books or records of an ITCRO or in records relating to reports of examinations, operations, or conditions, including working papers, of an ITCRO.

Section 2 amends s. 663.540, F.S., to save from repeal and reenact the current public records exemption relating to a personal identifying information of the customers or prospective customers of an affiliated international trust entity, which appear in the books or records of a qualified limited service affiliate or in records relating to reports of examinations, operations, or conditions, including working papers, of a qualified limited service affiliate.

[35] Section 663.540(3), F.S., authorizes OFR to release of such confidential and exempt information to specified entities.
[36] Office of Financial Regulation, Response to OGSR Survey of OFR Public Records Exemptions (Sept. 30, 2021) (on file with Senate Banking and Insurance Committee).
[37] *Id.*
[38] *Id.* Only three of the requested records were completely confidential and exempt and were not provided.

Section 3 amends s. 655.057, F.S. to save from repeal and reenact the current public records exemptions in subsections (1), (2), (5), and (9) that apply to financial institutions, generally, relating to investigations, reports of examination, operations, condition, including working papers.

Section 4 provides an effective date of October 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Not applicable. The bill does not require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

B. Public Records/Open Meetings Issues:

Vote Requirement
Article I, section 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records requirements. This bill continues current public records exemptions beyond their current date of repeal. The bill does not create or expand an exemption. Thus, the bill does not require an extraordinary vote for enactment.

Public Necessity Statement
Article I, s. 24(c) of the State Constitution requires a bill creating or expanding an exemption to the public records requirements to state with specificity the public necessity justifying the exemption. This bill continues a current public records exemption without expansion. Thus, a statement of public necessity is not required.

Breadth of Exemption
Article I, s. 24(c) of the State Constitution requires an exemption to the public records requirements to be no broader than necessary to accomplish the stated purpose of the law. The exemptions do not appear to be broader than necessary to accomplish the purpose of the law.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The private sector will continue to be subject to the cost associated with an agency making redactions in response to a public records request.

C. Government Sector Impact:

The governmental agency, Office of Financial Regulation, will continue to incur costs related to the redaction of records in responding to public records requests.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 663.416, 663.540, and 657.057.

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.

FOR CONSIDERATION By the Committee on Banking and Insurance

597-00865-22 20227020pb

A bill to be entitled

An act relating to review under the Open Government Sunset Review Act; amending s. 663.416, F.S., which provides an exemption from public records requirements for certain information held by the Office of Insurance Regulation relating to affiliated international trust entities; removing the scheduled repeal of the exemption; amending s. 663.540, F.S., which provides an exemption from public records requirements for certain information held by the office relating to qualified limited service affiliates; removing the scheduled repeal of the exemption; amending s. 655.057, F.S., which provides exemptions from public records requirements for certain information held by the office relating to active investigations of and the regulation of financial institutions; removing the scheduled repeal of the exemption; providing an effective date.

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

Section 1. Section 663.416, Florida Statutes, is amended to read:

663.416 Public records exemption.—

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

(a) "Reports of examinations, operations, or condition" means records submitted to or prepared by the office as part of the office's duties performed pursuant to s. 655.012 or s. 655.045.

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

597-00865-22 20227020pb

(b) "Working papers" means the records of the procedure followed, the tests performed, the information obtained, and the conclusions reached in an investigation or examination performed under s. 655.032 or s. 655.045. The term includes planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of the books and records of a financial institution, as defined in s. 655.005, and schedules or commentaries prepared or obtained in the course of such investigation or examination.

(2) PUBLIC RECORDS EXEMPTION.—The following information held by the office is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Any personal identifying information of the customers or prospective customers of an affiliated international trust entity which appears in the books and records of an international trust company representative office or in records relating to reports of examinations, operations, or condition of an international trust company representative office, including working papers.

(b) Any portion of a list of names of the shareholders or members of an affiliated international trust entity.

(c) Information received by the office from a person from another state or country or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or country or pursuant to federal law.

(3) AUTHORIZED RELEASE OF CONFIDENTIAL AND EXEMPT INFORMATION.—Information made confidential and exempt under subsection (2) may be disclosed by the office:

(a) To the authorized representative or representatives of

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

the international trust company representative office under examination. The authorized representative or representatives must be identified in a resolution or by written consent of the board of directors, or the equivalent, of the international trust entity.

(b) To a fidelity insurance company, upon written consent of the board of directors, or the equivalent, of the international trust entity.

(c) To an independent auditor, upon written consent of the board of directors, or the equivalent, of the international trust entity.

(d) To the liquidator, receiver, or conservator for the international trust entity, if a liquidator, receiver, or conservator is appointed. However, any portion of the information which discloses the identity of a customer or prospective customer of the international trust entity, or a shareholder or member of the international trust entity, must be redacted by the office before releasing such portion to the liquidator, receiver, or conservator.

(e) To a law enforcement agency in furtherance of the agency's official duties and responsibilities.

(f) To the appropriate law enforcement or prosecutorial agency for the purpose of reporting any suspected criminal activity.

(g) Pursuant to a legislative subpoena. A legislative body or committee that receives records or information pursuant to such a subpoena must maintain the confidential status of the records or information, except in a case involving the investigation of charges against a public official subject to

impeachment or removal, in which case the records or information may be disclosed only to the extent necessary as determined by such legislative body or committee.

(4) PUBLICATION OF INFORMATION.—This section does not prevent or restrict the publication of a report required by federal law.

(5) PENALTY.—A person who willfully, in violation of this section, discloses information made confidential and exempt by this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

~~(6) OPEN GOVERNMENT SUNSET REVIEW.—This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and is repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.~~

Section 2. Section 663.540, Florida Statutes, is amended to read:

663.540 Public records exemption.—

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

(a) "Reports of examinations, operations, or condition" means records submitted to or prepared by the office as part of the office's duties performed pursuant to s. 655.012 or s. 663.537.

(b) "Working papers" means the records of the procedure followed, the tests performed, the information obtained, and the conclusions reached in an investigation or examination performed under s. 655.032 or s. 663.537. The term includes planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of the books and records of a financial institution, as defined in s. 655.005,

and schedules or commentaries prepared or obtained in the course of such investigation or examination.

(2) PUBLIC RECORDS EXEMPTION.—The following information held by the office is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Any personal identifying information of the customers or prospective customers of an affiliated international trust entity which appears in the books and records of a qualified limited service affiliate or in records relating to reports of examinations, operations, or condition of a qualified limited service affiliate, including working papers.

(b) Any portion of a list of names of the shareholders or members of a qualified limited service affiliate.

(c) Information received by the office from a person from another state or country or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or country or pursuant to federal law.

(3) AUTHORIZED RELEASE OF CONFIDENTIAL AND EXEMPT INFORMATION.—Information made confidential and exempt under subsection (2) may be disclosed by the office:

(a) To the authorized representative or representatives of the qualified limited service affiliate under examination. The authorized representative or representatives must be identified in a resolution or by written consent of the board of directors, if the qualified limited service affiliate is a corporation, or of the managers, if the qualified limited service affiliate is a limited liability company.

(b) To a fidelity insurance company, upon written consent of the qualified limited service affiliate's board of directors,

if the qualified limited service affiliate is a corporation, or of the managers, if the qualified limited service affiliate is a limited liability company.

(c) To an independent auditor, upon written consent of the qualified limited service affiliate's board of directors, if the qualified limited service affiliate is a corporation, or of the managers, if the qualified limited service affiliate is a limited liability company.

(d) To the liquidator, receiver, or conservator for a qualified limited service affiliate, if a liquidator, receiver, or conservator is appointed. However, any portion of the information which discloses the identity of a customer of the affiliated international trust entity, or a shareholder or member of the qualified limited service affiliate, must be redacted by the office before releasing such portion to the liquidator, receiver, or conservator.

(e) To a law enforcement agency in furtherance of the agency's official duties and responsibilities.

(f) To the appropriate law enforcement or prosecutorial agency for the purpose of reporting any suspected criminal activity.

(g) Pursuant to a legislative subpoena. A legislative body or committee that receives records or information pursuant to such a subpoena must maintain the confidential status of the records or information, except in a case involving the investigation of charges against a public official subject to impeachment or removal, in which case the records or information may be disclosed only to the extent necessary as determined by such legislative body or committee.

(4) PUBLICATION OF INFORMATION.—This section does not prevent or restrict the publication of a report required by federal law.

(5) PENALTY.—A person who willfully, in violation of this section, discloses information made confidential and exempt by this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

~~(6) OPEN GOVERNMENT SUNSET REVIEW.—This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and is repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.~~

Section 3. Section 655.057, Florida Statutes, is amended to read:

655.057 Records; limited restrictions upon public access.—

(1) Except as otherwise provided in this section and except for such portions thereof which are otherwise public record, all records and information relating to an investigation by the office are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution until such investigation is completed or ceases to be active. For purposes of this subsection, an investigation is considered "active" while such investigation is being conducted by the office with a reasonable, good faith belief that it may lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the office is proceeding with reasonable dispatch, and there is a good faith belief that action may be initiated by the office or other administrative or law enforcement agency. After an investigation is completed or ceases to be active, portions of the records relating to the

investigation are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution to the extent that disclosure would:

(a) Jeopardize the integrity of another active investigation;

(b) Impair the safety and soundness of the financial institution;

(c) Reveal personal financial information;

(d) Reveal the identity of a confidential source;

(e) Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual; or

(f) Reveal investigative techniques or procedures.

(2) Except as otherwise provided in this section and except for such portions thereof which are public record, reports of examinations, operations, or condition, including working papers, or portions thereof, prepared by, or for the use of, the office or any state or federal agency responsible for the regulation or supervision of financial institutions in this state are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, such reports or papers or portions thereof may be released to:

(a) The financial institution under examination;

(b) Any holding company of which the financial institution is a subsidiary;

(c) Proposed purchasers if necessary to protect the continued financial viability of the financial institution, upon prior approval by the board of directors of such institution;

(d) Persons proposing in good faith to acquire a

controlling interest in or to merge with the financial institution, upon prior approval by the board of directors of such financial institution;

(e) Any officer, director, committee member, employee, attorney, auditor, or independent auditor officially connected with the financial institution, holding company, proposed purchaser, or person seeking to acquire a controlling interest in or merge with the financial institution; or

(f) A fidelity insurance company, upon approval of the financial institution's board of directors. However, a fidelity insurance company may receive only that portion of an examination report relating to a claim or investigation being conducted by such fidelity insurance company.

(g) Examination, operation, or condition reports of a financial institution shall be released by the office within 1 year after the appointment of a liquidator, receiver, or conservator to the financial institution. However, any portion of such reports which discloses the identities of depositors, bondholders, members, borrowers, or stockholders, other than directors, officers, or controlling stockholders of the institution, shall remain confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Any confidential information or records obtained from the office pursuant to this paragraph shall be maintained as confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) Except as otherwise provided in this section and except for those portions that are otherwise public record, after an

investigation relating to an informal enforcement action is completed or ceases to be active, informal enforcement actions are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution to the extent that disclosure would:

(a) Jeopardize the integrity of another active investigation.

(b) Impair the safety and soundness of the financial institution.

(c) Reveal personal financial information.

(d) Reveal the identity of a confidential source.

(e) Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual.

(f) Reveal investigative techniques or procedures.

(4) Except as otherwise provided in this section and except for those portions that are otherwise public record, trade secrets as defined in s. 688.002 which comply with s. 655.0591 and which are held by the office in accordance with its statutory duties with respect to the financial institutions codes are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(5) This section does not prevent or restrict:

(a) Publishing reports that are required to be submitted to the office pursuant to s. 655.045(2) or required by applicable federal statutes or regulations to be published.

(b) Furnishing records or information to any other state, federal, or foreign agency responsible for the regulation or supervision of financial institutions.

(c) Disclosing or publishing summaries of the condition of

financial institutions and general economic and similar statistics and data, provided that the identity of a particular financial institution is not disclosed.

(d) Reporting any suspected criminal activity, with supporting documents and information, to appropriate law enforcement and prosecutorial agencies.

(e) Furnishing information upon request to the Chief Financial Officer or the Division of Treasury of the Department of Financial Services regarding the financial condition of any financial institution that is, or has applied to be, designated as a qualified public depository pursuant to chapter 280.

(f) Furnishing information to Federal Home Loan Banks regarding its member institutions pursuant to an information sharing agreement between the Federal Home Loan Banks and the office.

Any confidential information or records obtained from the office pursuant to this subsection shall be maintained as confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(6)(a) Orders of courts or of administrative law judges for the production of confidential records or information must provide for inspection in camera by the court or the administrative law judge. After the court or administrative law judge determines that the documents requested are relevant or would likely lead to the discovery of admissible evidence and that the information sought is not otherwise reasonably available from other sources, the documents shall be subject to further orders by the court or the administrative law judge to

protect the confidentiality thereof. An order directing the release of information is immediately reviewable, and a petition by the office for review of such order automatically stays further proceedings in the trial court or the administrative hearing until the disposition of such petition by the reviewing court. If any other party files such a petition for review, it operates as a stay of such proceedings only upon order of the reviewing court.

(b) Confidential records and information furnished pursuant to a legislative subpoena shall be kept confidential by the legislative body or committee that received the records or information. However, in a case involving investigation of charges against a public official subject to impeachment or removal, disclosure of such information shall be only to the extent necessary as determined by the legislative body or committee.

(c) Documents, statements, books, records, and any other information provided to the office by any person pursuant to an investigation, examination, or other supervisory activity by the office are not considered a waiver of any privilege or other legal right in an administrative or legal proceeding in which the office is not a party.

(7) Every credit union and mutual association shall maintain full and correct records of the names and residences of all the members of the credit union or mutual association in the principal office where its business is transacted. Such records are subject to inspection by all members of the credit union or mutual association, and the officers authorized to assess taxes under state authority, during normal business hours. No member

or any other person has the right to copy the membership records for any purpose other than in the course of business of the credit union or mutual association, as authorized by the office or the board of directors of the credit union or mutual association. A current list of members shall be made available to the office's examiners for their inspection and, upon the request of the office, shall be submitted to the office. Except as otherwise provided in this subsection, the list of the members of the credit union or mutual association is confidential and exempt from s. 119.07(1).

(8) Every bank, trust company, and stock association shall maintain, in the principal office where its business is transacted, full and complete records of the names and residences of all the shareholders of the bank, trust company, or stock association and the number of shares held by each. Such records are subject to the inspection of all the shareholders of the bank, trust company, or stock association, and the officers authorized to assess taxes under state authority, during normal business hours. No shareholder or any other person has the right to copy the shareholder records for any purpose other than in the course of business of the bank, the trust company, or the stock association, as authorized by the office or the board of directors of the bank, the trust company, or the stock association. A current list of shareholders shall be made available to the office's examiners for their inspection and, upon the request of the office, shall be submitted to the office. Except as otherwise provided in this subsection, any portion of this list which reveals the identities of the shareholders is confidential and exempt from s. 119.07(1).

(9) Materials supplied to the office or to employees of any financial institution by other state or federal governmental agencies remain the property of the submitting agency or the corporation, and any document request must be made to the appropriate agency. Any confidential documents supplied to the office or to employees of any financial institution by other state or federal governmental agencies are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such information shall be made public only with the consent of such agency or the corporation.

(10) Examination reports, investigatory records, applications, and related information compiled by the office, or photographic copies thereof, shall be retained by the office for at least 10 years.

(11) A copy of any document on file with the office which is certified by the office as being a true copy may be introduced in evidence as if it were the original. The commission shall establish a schedule of fees for preparing true copies of documents.

(12) For purposes of this section, the term:

(a) "Examination report" means records submitted to or prepared by the office as part of the office's duties performed pursuant to s. 655.012 or s. 655.045(1).

(b) "Informal enforcement action" means a board resolution, a document of resolution, or an agreement in writing between the office and a financial institution which:

1. The office imposes on an institution when the office considers the administrative enforcement guidelines in s. 655.031 and determines that a formal enforcement action is not

an appropriate administrative remedy;

2. Sets forth a program of corrective action to address one or more safety and soundness deficiencies and violations of law or rule at the institution; and

3. Is not subject to enforcement by imposition of an administrative fine pursuant to s. 655.041.

(c) "Personal financial information" means:

1. Information relating to the existence, nature, source, or amount of a person's personal income, expenses, or debt.

2. Information relating to a person's financial transactions of any kind.

3. Information relating to the existence, identification, nature, or value of a person's assets, liabilities, or net worth.

(d) "Working papers" means the records of the procedures followed, the tests performed, the information obtained, and the conclusions reached in an examination or investigation performed under s. 655.032 or s. 655.045. Working papers include planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of the books and records of a financial institution as defined in s. 655.005(1), and schedules or commentaries prepared or obtained in the course of such examination or investigation.

(13) A person who willfully discloses information made confidential by this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

~~(14) Subsections (1), (2), (5), and (9) are subject to the Open Government Sunset Review Act in accordance with s. 119.15~~

~~and are repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.~~

Section 4. This act shall take effect October 1, 2022.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Governmental Oversight and Accountability, *Chair*
Criminal Justice, *Vice Chair*
Appropriations
Banking and Insurance
Rules

SENATOR JEFF BRANDES
24th District

November 17, 2021

Chair Boyd,

I am writing to request respectfully that I be excused from the December 1st Banking and Insurance committee meeting.

If you have any questions regarding this request, please feel free to contact my office, or myself. Thank you for time and consideration of this matter.

Kind Regards,

Jeff Brandes

REPLY TO:
☐ 9800 4th Street North, Suite 200, St. Petersburg, Florida 33702 (727) 563-2100
☐ 414 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5024

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

WILTON SIMPSON
President of the Senate

AARON BEAN
President Pro Tempore

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Committee on Banking and Insurance **Judge:**

Started: 12/1/2021 8:32:13 AM
Ends: 12/1/2021 10:21:24 AM Length: 01:49:12

8:32:12 AM Meeting called to order
8:32:24 AM Roll Call
8:32:56 AM Tab 5 - SB 838 Fire Investigators by Senator Wright
8:34:39 AM Questions on the bill
8:34:44 AM Appearance cards
8:34:52 AM Chief Ray Colburn, Florida Fire Chiefs Association, waives in support
8:35:08 AM Jeffrey Newsome, President, Professional Firefighters, waives in support
8:35:16 AM Senator Wright waives close
8:35:19 AM Roll call on SB 838
8:35:24 AM SB 838 is reported favorably
8:36:03 AM Austin Stowers, Department of Financial Services, State Fire Marshal Office, late card on SB 838, waives in support
8:36:41 AM Chair Boyd discusses moving to presentation on Tab 1, moves to Tab 4
8:36:49 AM Tab 4 - SB 546 Consumer Finance Loans by Senator Gruters
8:38:11 AM Questions
8:38:17 AM Appearance cards
8:38:21 AM Scott Jenkins, Florida Financial Services Association, waives in support
8:38:32 AM Senator Gruters waives close
8:38:38 AM Roll call on SB 546
8:38:44 AM SB 546 is reported favorably
8:39:25 AM Tab 1 - Presentations on the Florida Birth-Related Neurological Injury Compensation Association
8:39:37 AM Comments regarding presentation by Chair Boyd
8:40:38 AM Susanne Murphy, Deputy Commissioner, Office of Insurance Regulation
9:01:20 AM Chair Boyd comments
9:01:24 AM Senator Stewart asks a question
9:01:32 AM Response by Susanne Murphy
9:01:44 AM Senator Stewart asks a question
9:01:51 AM Susanne Murphy responds
9:02:07 AM Senator Broxson asks a question
9:03:53 AM Chair Boyd comments
9:03:55 AM Susanne Murphy responds
9:05:29 AM Chair Boyd moves to presentation by Josh Barrett, Office of the Auditor General
9:06:35 AM Josh Barrett, Office of the Auditor General
9:17:13 AM Chair Boyd moves to questions
9:17:19 AM Senator Taddeo asks a question
9:17:30 AM Josh Barrett responds
9:17:30 AM Chair asks if there are other questions
9:17:46 AM Senator Passsidomo for a comment
9:19:31 AM Chair Boyd comments
9:19:39 AM Brian Meyer, Assistant Depty Secretary, Agency for Health Care Administration
9:25:02 AM Senator Boyd comments
9:25:25 AM Jim DeBeaugrine, Florida Birth-Related Neurological Injury Compensation Association
9:30:46 AM Chair Boyd comments
9:30:52 AM Melissa Jaacks, Florida Birth-Related Neurological Injury Compensation Association
9:39:58 AM Chair Boyd comments
9:40:12 AM Senator Burgess for a comment
9:41:10 AM Senator Boyd comments
9:41:43 AM Tab 2 - SB 312 Telehealth by Senator Diaz
9:43:22 AM Questions by Senator Thurston and response by Senator Diaz
9:44:22 AM Appearnce Cards
9:44:26 AM Dr. Barry Gordon speaking for the bill
9:45:45 AM Dr. Kevin Hughes speaking for the bill

9:46:33 AM Dr. Melanie Bone speaking for the bill
9:48:08 AM Senator Broxson asks a question
9:48:20 AM Melanie Bone responds
9:49:51 AM Senator Thurston asks a question
9:50:14 AM Melanie Bone responds
9:50:30 AM Dr. Barry Gordon responds to prior questions from Senator Broxson and Senator Thurston
9:51:51 AM Chair Boyd and Senator Thurston comment
9:52:32 AM David Mica, Jr., Florida Hospital Association, waives in support
9:52:33 AM Chris Nuland, Florida Chapter, American College of Physicians, waives in support
9:52:34 AM Aimee Diaz Lyon, Florida Academy of Family Physicians waives, in support
9:52:40 AM Chris Lyon, Florida Osteopathic Medical Association, waives in support
9:52:45 AM Mary Thomas, Florida Medical Association, waives in support
9:52:51 AM Phillip Suderman, Americans for Prosperity, waives in support
9:53:04 AM Tiffany Henderson, American Heart Association, waives in support
9:53:13 AM Debate
9:53:17 AM Senator Taddeo in debate
9:54:39 AM Senator Diaz closes on the bill
9:55:37 AM Roll call on SB 312
9:55:51 AM SB 312 is reported favorably
9:56:15 AM Tab 3 - SB 468 Insurance by Senator Perry
9:57:34 AM Senator Rouson asks a question
9:57:38 AM Senator Perry responds
9:58:47 AM Senator Rouson asks a question
9:58:53 AM Senator Perry responds
9:59:36 AM Senator Thurston asks a question
9:59:44 AM Senator Perry responds
10:00:50 AM Chair allows Senators to continue back and forth
10:00:52 AM Senator Thurston asks a question
10:01:19 AM Senator Perry responds
10:01:51 AM Senator Thurston asks a question
10:01:57 AM Senator Perry responds
10:02:29 AM Senator Thurston asks a question
10:02:33 AM Senator Perry responds
10:03:13 AM Senator Rodrigues asks a question
10:03:38 AM Senator Perry responds
10:04:11 AM Take up amendment barcode 868608 then to substitute barcode 951404
10:04:54 AM Substitute amendment barcode 951404 adopted
10:05:11 AM Appearance cards
10:05:18 AM Josh Aubuchon, State Farm, waives in support
10:05:24 AM BG Murphy, Florida Association of Insurance Agents, waives in support
10:05:37 AM Candace Bunker, Citizens Property Insurance Corporation, waives in support
10:05:44 AM Scott Matiyow, PIFF, waives in support
10:05:52 AM Steve Cain speaking against the bill
10:06:36 AM Molli McGuire speaking against the bill
10:09:34 AM Debate on the bill as amended
10:09:39 AM Senator Rouson in debate
10:11:01 AM Senator Thurston in debate
10:11:42 AM Senator Rodrigues in debate
10:12:03 AM Senator Perry to close
10:12:09 AM Roll call on CS for SB 468
10:12:25 AM CS/SB 468 is reported favorably
10:13:06 AM Chair Boyd turn the chair over to Vice Chair Broxson
10:13:44 AM Tab 6 - SPB 7016 by BI, OGSR/Information Submitted by Insurers/Department of Financial Services
10:13:55 AM Chair Boyd explains SPB 7016
10:14:17 AM Senator Rodrigues asks a question
10:14:28 AM Chair Boyd responds
10:14:45 AM Chair Boyd moves that SPB 7016 be submitted as a committee bill
10:15:14 AM Motion adopted without opposition
10:15:20 AM Roll Call on SPB 7016
10:15:42 AM SPB 7016 is reported favorably
10:15:48 AM Tab 7 - SPB 7018 by BI, OGSR/Insured or Deceased Employee/Department of Financial Services
10:15:51 AM Chair Boyd explains SPB 7018

10:16:36 AM Austin Stowers, DFS, waives in support
10:16:46 AM Senator Boyd moves SPB 7018 is submitted as a committee bill; motion adopted without opposition
10:17:13 AM Roll call on SPB 7018
10:17:21 AM SPB 7018 is reported favorably
10:17:43 AM Tab 8 - SPB 7020 by BI, OGSR/Office of Insurance Regulation
10:17:56 AM Chair Boyd explains SPB 7020
10:19:15 AM Senator Boyd moves that SPB 7020 be submitted as a committee bill; motion adopted without opposition
10:19:29 AM Roll call on SPB 7020
10:19:35 AM SPB 7020 is reported favorably
10:20:01 AM Senator Broxson turns chair back to Chair Boyd
10:20:14 AM Chair Boyd comments
10:21:02 AM Vice Chair moves to adjourn without objection meeting adjourned