Tab 1	**SB 342** by **Gibson**; (Compare to CS/H 0237) Renter Insurance						
417300	A	S	L	RCS	BI, Detert	Delete L.13 - 24:	01/27 04:44 PM
Tab 2	**SB 596** by **Hukill**; (Similar to H 1097) Assignment or Transfer of Property Insurance Rights						
415826	A	S			BI, Clemens	Delete L.32 - 49:	01/25 08:16 PM
751400	A	S			BI, Clemens	Delete L.72 - 76:	01/25 08:15 PM
Tab 3	**SB 650** by **Legg**; (Similar to CS/H 0445) Viatical Settlements						
184016	D	S		RCS	BI, Richter	Delete everything after	01/27 04:47 PM
Tab 4	**CS/SB 676** by **HP, Grimsley**; (Compare to H 0423) Access to Health Care Services						
821310	A	S	L	RCS	BI, Richter	Delete L.928 - 942:	01/27 04:50 PM
Tab 5	**SB 986** by **Simpson**; (Identical to H 0613) Workers' Compensation System Administration						
756866	A	S			BI, Smith	Delete L.45 - 110:	01/25 07:03 AM
Tab 6	**SB 1036** by **Brandes**; (Similar to CS/H 0659) Automobile Insurance						
911596	A	S		RCS	BI, Richter	Before L.36:	01/27 04:53 PM
683016	A	S		RCS	BI, Richter	Delete L.154 - 217:	01/27 04:53 PM
Tab 7	**SB 1120** by **Abruzzo**; (Similar to CS/H 0875) Motor Vehicle Service Agreement Companies						
216566	A	S		RCS	BI, Clemens	Delete L.93 - 108:	01/26 11:59 AM
Tab 8	**SB 1164** by **Legg**; (Similar to H 0965) Firesafety						
901942	A	S		RCS	BI, Richter	Delete L.27 - 28:	01/26 11:59 AM
Tab 9	**SB 1170** by **Detert**; (Similar to H 0951) Health Plan Regulatory Administration						
~~724686~~	A	S		WD	BI, Detert	Delete L.206 - 215.	01/26 11:59 AM
~~192718~~	A	S		WD	BI, Detert	Delete L.277 - 334.	01/26 11:59 AM
747432	D	S	L	RCS	BI, Detert	Delete everything after	01/26 11:59 AM
Tab 10	**SB 1386** by **Richter**; (Similar to H 1303) Life Insurers						
709918	D	S		RCS	BI, Richter	Delete everything after	01/26 11:59 AM
Tab 11	**SB 1422** by **Simmons**; (Similar to CS/H 1163) Insurer Regulatory Reporting						
728084	A	S	L	RCS	BI, Simmons	Delete L.327 - 328:	01/26 11:59 AM
197750	A	S	L	RCS	BI, Simmons	Delete L.346:	01/26 11:59 AM
884538	A	S	L	RCS	BI, Simmons	Delete L.119 - 194:	01/26 11:59 AM
Tab 12	**SB 1416** by **Simmons**; (Similar to CS/H 1165) Public Records/Own-risk and Solvency Assessment/Corporate Governance Annual Disclosure						
158654	A	S	L	RCS	BI, Simmons	Delete L.104:	01/27 08:56 AM
647128	A	S	L	RCS	BI, Simmons	Delete L.24:	01/27 08:56 AM
Tab 13	**SB 1106** by **Flores**; (Similar to H 1383) Limited Purpose International Trust Company Representative Offices						

Tab 14	**SB 1094** by **Flores**; (Similar to H 1385) Public Records/Limited Purpose International Trust Company

972696	A	S	RCS	BI, Simmons	Delete L.156:	01/26 12:00 PM

Tab 15	**SB 632** by **Richter**; (Similar to H 0005) Civil Remedies Against Insurers

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Benacquisto, Chair
Senator Richter, Vice Chair

MEETING DATE: Tuesday, January 26, 2016
TIME: 9:00—11:00 a.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Benacquisto, Chair; Senator Richter, Vice Chair; Senators Clemens, Detert, Hukill, Lee, Margolis, Montford, Negron, Simmons, and Smith

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 342** Gibson (Identical S 94, Compare CS/H 237)	Renter Insurance; Requiring a residential rental agreement to specify whether renter insurance is required; specifying provisions that must be included if insurance is or is not required, etc. BI 01/26/2016 Fav/CS JU RC	Fav/CS Yeas 9 Nays 0
2	**SB 596** Hukill (Similar H 1097)	Assignment or Transfer of Property Insurance Rights; Providing requirements under a property insurance policy for the post-loss assignment or transfer of rights, benefits, or policy provisions not related to liability coverage; providing requirements for an agreement to assign or transfer such rights, benefits, or policy provisions; providing prohibitions and conditions that void such an agreement; providing applicability, etc. BI 01/26/2016 Temporarily Postponed JU RC	Temporarily Postponed
3	**SB 650** Legg (Similar CS/H 445)	Viatical Settlements; Defining the terms “business of viatical settlements,” “fraudulent viatical settlement act,” and “stranger-originated life insurance practice”; requiring additional information in an annual statement filed by viatical settlement provider licensees; adding an act that warrants the imposition of administrative penalties against viatical settlement provider licensees; requiring viatical settlement providers to provide viators with a disclosure statement before or concurrently with a viator’s execution of a viatical settlement contract, etc. BI 01/26/2016 Fav/CS AGG AP	Fav/CS Yeas 8 Nays 1

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 676** Health Policy / Grimsley (Similar S 210, S 428, Compare H 423, H 471, H 977, S 586, S 1250)	Access to Health Care Services; Expanding the categories of persons who may prescribe brand name drugs under the prescription drug program when medically necessary; requiring a hospital to provide specified advance notice to certain obstetrical physicians before it closes its obstetrical department or ceases to provide obstetrical services; requiring the Board of Nursing to establish a committee to recommend a formulary of controlled substances that may not be prescribed, or may be prescribed only on a limited basis, by an advanced registered nurse practitioner; requiring that certain health insurers that do not already use a certain form use only a prior authorization form approved by the Financial Services Commission, etc. HP 01/11/2016 Fav/CS BI 01/26/2016 Fav/CS AHS AP	Fav/CS Yeas 9 Nays 0
5	**SB 986** Simpson (Identical H 613)	Workers' Compensation System Administration; Requiring members of limited liability companies to submit specified notices; requiring that the Department of Financial Services allow an employer who has not previously been issued an order of penalty assessment to receive a specified credit to be applied to the penalty; eliminating the certification requirements when an expert medical advisor is selected by a judge of compensation claims; deleting the requirement that employers notify the department within 24 hours of any injury resulting in death, etc. BI 01/26/2016 Temporarily Postponed AGG AP	Temporarily Postponed
6	**SB 1036** Brandes (Similar CS/H 659)	Automobile Insurance; Authorizing the Florida Automobile Joint Underwriting Association and a joint underwriting plan approved by the Office of Insurance Regulation to cancel personal lines or commercial policies within a specified time for nonpayment of premium due to certain reasons; authorizing an insurer to opt out of the preinsurance inspection of private passenger motor vehicles and to establish its own preinsurance inspection program if it files a certain manual rule with the office, etc. BI 01/26/2016 Fav/CS CM RC	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1120** Abruzzo (Similar CS/H 875)	Motor Vehicle Service Agreement Companies; Revising and providing definitions, etc. BI 01/26/2016 Fav/CS CM RC	Fav/CS Yeas 9 Nays 0
8	**SB 1164** Legg (Similar H 965)	Firesafety; Requiring the State Fire Marshal to adopt uniform firesafety standards for assisted living facilities; revising provisions relating to the minimum standards that must be adopted by the Department of Elderly Affairs for firesafety in assisted living facilities; clarifying the fees a utility may charge for the installation and maintenance of an automatic fire sprinkler system, etc. BI 01/26/2016 Fav/CS CF FP	Fav/CS Yeas 9 Nays 0
9	**SB 1170** Detert (Similar H 951)	Health Plan Regulatory Administration; Revising a provision specifying that certain sections of the Florida Insurance Code do not apply to a group health insurance policy as that policy relates to specified benefits, under certain circumstances; repealing provisions relating to preexisting conditions; redefining the term “creditable coverage”, etc. BI 01/26/2016 Fav/CS AHS AP	Fav/CS Yeas 9 Nays 0
10	**SB 1386** Richter (Similar H 1303)	Life Insurers; Revising the maximum limit of coverage of a specified life insurance policy that may be sold by a funeral director, a direct disposer, or an employee of a funeral establishment under certain circumstances, etc. BI 01/26/2016 Fav/CS CM RC	Fav/CS Yeas 9 Nays 0
11	**SB 1422** Simmons (Similar H 1163, Compare H 1165, Linked S 1416)	Insurer Regulatory Reporting; Requiring an insurer to maintain a risk management framework; requiring certain insurers and insurance groups to conduct an own-risk and solvency assessment; requiring certain insurers and members of an insurance group to prepare and submit a corporate governance annual disclosure, etc. BI 01/26/2016 Fav/CS AGG AP	Fav/CS Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
12	**SB 1416** Simmons (Identical H 1165, Compare H 1163, Linked S 1422)	Public Records/Own-risk and Solvency Assessment/Corporate Governance Annual Disclosure; Providing an exemption from public records requirements for certain reports and documents submitted to the Office of Insurance Regulation related to an own-risk and solvency assessment by an insurer or insurance group; providing an exemption from public records requirements for a corporate governance annual disclosure and supporting documents submitted to the office; providing for and revising future legislative review and repeal; providing a statement of public necessity, etc. BI 01/26/2016 Fav/CS GO RC	Fav/CS Yeas 9 Nays 1
13	**SB 1106** Flores (Similar H 1383, Compare H 1385, Linked S 1094)	Limited Purpose International Trust Company Representative Offices; Providing applicability of state banking laws to limited purpose international trust company representative offices; exempting a limited purpose international trust company representative office from licensing requirements; exempting applications for registration of limited purpose international trust company representative offices from certain provisions of ch. 120, F.S.; specifying permissible and prohibited activities by a limited purpose international trust company representative office and by certain employees, etc. BI 01/26/2016 Favorable AGG AP	Favorable Yeas 8 Nays 2
14	**SB 1094** Flores (Similar H 1385, Compare H 1383, Linked S 1106)	Public Records/Limited Purpose International Trust Company; Providing an exemption from public records requirements for certain information held by the Office of Financial Regulation relating to a limited purpose international trust company representative office; authorizing the release of certain confidential and exempt information by the office; providing a statement of public necessity, etc. BI 01/26/2016 Fav/CS GO RC	Fav/CS Yeas 6 Nays 4

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
15	**SB 632** Richter (Similar H 5)	Civil Remedies Against Insurers; Requiring an insured, a claimant, or a person acting on behalf of an insured or a claimant to provide an insurer with written notice of loss as a condition precedent to bringing a statutory or common-law action for a third-party bad faith action for failure to settle an insurance claim, etc. BI 01/19/2016 Temporarily Postponed BI 01/26/2016 Temporarily Postponed JU RC	Temporarily Postponed

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 342
INTRODUCER:	Banking and Insurance Committee and Senator Gibson
SUBJECT:	Renter Insurance
DATE:	January 27, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Fav/CS**
2.			JU	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 342 requires a landlord of residential real property to provide notice in the rental agreement whether the tenant is required to obtain renter insurance and, if so, to specify the coverage required. If the rental agreement specifies renter insurance is not required, the notice must provide a statement regarding the benefit of purchasing renters insurance.

II. Present Situation:

Part II of ch. 83, F.S., entitled the "Florida Residential Landlord and Tenant Act," or "Act," governs the relationship between landlords and tenants under a residential rental agreement. The Act contains certain mandatory or conditional provisions and disclosures that a landlord must provide to a tenant or prospective tenant. For example:

- If the landlord requires a security deposit, the Act requires a disclosure regarding the tenant's rights and responsibilities with respect to the security deposit.[1]
- The landlord must disclose his or her address.[2]
- If there is a liquidated damages provision in the lease, the Act provides language that must be included in the lease.[3]

[1] s. 83.49(2)(d), F.S.
[2] s. 83.50, F.S.
[3] s. 83.595(4), F.S.

- If the rental agreement indemnifies the landlord for storage or disposition of personal property of the tenant after the tenant surrenders the dwelling, the Act requires language within the lease to notify the tenant to that effect.[4]

The common term "renter insurance" refers to an insurance product that is also sometimes referred to as a "contents policy." Such insurance indemnifies a tenant for loss or damage to the tenant's personal property within the rental unit, and is generally packaged with liability coverage. In essence, it is a homeowner's policy without coverage for the structure. While nearly all homeowners carry homeowners insurance, a 2014 study showed that only 37 percent of tenants buy a renters insurance policy.[5]

III. Effect of Proposed Changes:

The bill creates s. 83.491, F.S., to require that a landlord make one of two notices in the lease agreement regarding renter insurance.

1. If renter insurance is required by the landlord, the rental agreement must specify the coverage amounts required and provide space for the tenant to initial.
2. If the landlord does not require the purchase of renter insurance, the rental agreement must include a statement providing substantially the following form:

> "The tenant is not required to obtain renter insurance; however, the tenant is strongly advised to obtain renter insurance to cover damage to or loss of personal property."

The bill clarifies that failure to provide such notice does not create a private cause of action or nullify any part of the rental agreement.

The bill has an effective date of July 1, 2016, and applies to any residential lease entered into on or after January 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[4] s. 83.67(5), F.S.
[5] http://www.iii.org/fact-statistic/renters-insurance, last accessed on January 14, 2016.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Landlords will need to provide one of two additional notices regarding renter insurance. If renters insurance is required the notice must be signed by the tenant. Tenants may benefit from being notified in the rental agreement that the purchase of renter insurance is necessary to cover damage personal property.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Real Property and Probate section of the Florida Bar drafts a standardized lease that includes all provisions required by state statue. The draft lease is reviewed and approved for use by the Supreme Court of Florida. The changes in the bill could require an updated standardized lease be drafted and approved.[6]

VIII. Statutes Affected:

This bill substantially amends section 83.491 of the Florida Statutes

IX. Additional Information:

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

CS by Banking and Insurance on January 26, 2016:

- Changes "Renter" to "Renters" throughout the bill.
- Applies the new notice requirements to leases entered into on or after January 1, 2017.
- Clarifies that failure to provide such notice does not create a private cause of action or nullify any part of the rental agreement.

B. Amendments:

None.

[6] Conversation with Arlene Catherine Udick of the Landlord Tenant Committee for the Real Property and Probate Trust Law Section of the Florida Bar Association (January 22, 2016).

417300

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/27/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Detert) recommended the following:

Senate Amendment (with title amendment)

Delete lines 13 - 24

and insert:

83.491 Renters insurance.—A rental agreement entered into on or after January 1, 2017, must specify whether a tenant is required to obtain renters insurance and must provide in the agreement a line for the tenant's initials immediately following that provision.

(1) If renters insurance is required, the rental agreement

417300

must specify the coverage required.

(2) If renters insurance is not required, the rental agreement must provide a statement in substantially the following form: "The tenant is not required to obtain renters insurance; however, the tenant is strongly advised to obtain renters insurance to cover damage to or loss of personal property."

(3) Failure to provide the notice in subsection (2) does not create a private cause of action and does not nullify any part of the rental agreement under this part.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete line 6

and insert:

insurance is or is not required; providing that failure to include a certain notice in a rental agreement does not create a private cause of action or nullify any part of the rental agreement; providing an

By Senator Gibson

9-00241-16 2016342__

A bill to be entitled

An act relating to renter insurance; creating s. 83.491, F.S.; requiring a residential rental agreement to specify whether renter insurance is required; specifying provisions that must be included if insurance is or is not required; providing an effective date.

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

Section 1. Section 83.491, Florida Statutes, is created to read:

83.491 Renter insurance.—A rental agreement must specify whether a tenant is required to obtain renter insurance and must provide in the agreement a line for the tenant's initials immediately following that provision.

(1) If renter insurance is required, the rental agreement must specify the coverage required.

(2) If renter insurance is not required, the rental agreement must provide a statement in substantially the following form: "The tenant is not required to obtain renter insurance; however, the tenant is strongly advised to obtain renter insurance to cover damage to or loss of personal property."

Section 2. This act shall take effect July 1, 2016.

342

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR AUDREY GIBSON
9th District

COMMITTEES:
Criminal Justice, Vice Chair
Military and Veterans Affairs, Space, and Domestic Security, Vice Chair
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Communications, Energy, and Public Utilities
Reapportionment
Rules

JOINT COMMITTEE:
Joint Legislative Auditing Committee

October 8, 2015

Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance
320 Knott Building
404 South Monroe Street
Tallahassee, Florida 32399-1100

Chair Benacquisto:

I respectfully request that SB 342, relating to residential tenant insurance policies, be placed on the next committee agenda.

SB 342, requires a residential agreement to advise that if renters insurance is not required, the renters' personal belongings will not be covered in the event of damage to their domicile unless they acquire renters insurance. I have also included a copy of a press release which details the coverage gap between and income owners and renters in protecting themselves against hazard as well as copies of newspaper articles on the subject.

Thank you for your time and consideration.

Sincerely,

Audrey Gibson
State Senator
District 9

Attachment

REPLY TO:
❒ 101 E. Union Street, Suite 104, Jacksonville, Florida 32202 (904) 359-2553 FAX: (904) 359-2532
❒ 205 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5009

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

01/26/2016
Meeting Date

SB 342
Bill Number (if applicable)

Topic Banking + Insurance

Amendment Barcode (if applicable)

Name Evelyn Bay-Rogers

Job Title Managing Partner, Bay-Rogers Insurance, LLC.

Address 9530 Regency Sq Blvd, Suite 104
Street

Phone (904) 642-3333

Jacksonville, FL
City *State* *Zip*

Email rayrogersinsurance@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Self

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

342
Bill Number (if applicable)

Topic Renters Insurance

Amendment Barcode (if applicable)

Name Kelly McMullen

Job Title

Address 104 W. Jefferson Street
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone 850-224-3427

Email Kelly@rlbodepa.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Apartment Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 596
INTRODUCER:	Senator Hukill
SUBJECT:	Assignment or Transfer of Property Insurance Rights
DATE:	January 25, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Pre-meeting**
2.			JU	
3.			RC	

I. Summary:

SB 596 provides that an agreement that purports to assign or transfer the right to enforce post-loss benefits in a property insurance policy is void. This provision would prevent the assignee from filing an action against the insurance company to enforce payment. This bill does not change current law regarding the right of insured to file an action against the insurance company and does not change current law regarding the rights of those who perform home repairs filing actions against homeowners.

The bill further provides that the assignment agreement is void if:

- It imposes a cancellation fee, a mortgage processing fee, or adds an amount for overhead and profit;
- The final invoice issued under the agreement exceeds the estimated cost for work performed and the increase was not authorized by the insurer;
- It prevents or inhibits an insurer from communicating with the insured at any time; or
- It purports to transfer or create any authority to adjust, negotiate, or settle any portion of a claim to a person not authorized to adjust, negotiate, or settle a claim.

This bill provides that for an assignment agreement to be valid all the following conditions must be met:

- The agreement must authorize a person or entity to be named as a payee or copayee for the benefit of payment for services rendered and materials provided to mitigate or repair covered damage only.
- The agreement must limit payment to $2,500 per occurrence for work performed to mitigate or repair covered damage.
- The agreement must be provided to the insured's property insurer within 3 business days after execution.

- The agreement must allow the insured to cancel the agreement within the later of 3 business days after the agreement is executed or submitted to the insurer. If the assignment agreement is for work resulting from a state of emergency declared by the Governor and is executed within 1 year of the declaration, the insured may cancel the assignment within 5 business days of its execution.
- The agreement must contain an estimate for proposed services and materials to be provided.

The bill provides that an agreement to assign post-loss benefits must contain a specific notice warning the insured that he or she is giving up certain rights and informing the insured of the right to rescind the agreement.

The bill does not apply to property insurance policy provisions relating to liability coverage.

This bill is effective upon becoming a law and its provisions apply to assignments executed after the effective date.

II. Present Situation:

Background on Assignment of Benefits

An assignment is the 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, such as the right to be paid, to another party. 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 can file a lawsuit against the insurer to recover the benefits.

Section 627.422, F.S., governs assignability of insurance contracts and provides that a policy may or may not be assignable according to its terms. In *Lexington Insurance Company v. Simkins Industries*,[1] the court held that a provision in an insurance contract prohibiting assignment was enforceable under the plain language of s. 627.422, F.S. The court explained that the purpose of a provision prohibiting assignment was to protect an insurer against unbargained-for risks.[2] However, Florida courts have held that an assignment made after the loss is valid even if the contract states otherwise.[3] In *Continental Casualty Company v. Ryan Incorporated*,[4] the court noted that it is a "well-settled rule that [anti-assignment provisions do] not apply to an assignment after loss. A court recently explained that the rationale for post-loss assignments is that "[a]n assignment of the policy, or rights under the policy, before the loss is incurred transfers the insurer's contractual relationship to a party with whom it never intended to contract, but an

[1] 704 So2d 1384 (Fla. 1998).
[2] *Id.* at 1386.
[3] *See West Florida Grocery Company v. Teutonia Fire Insurance Company*, 77 So. 209 (Fla. 1917); *Better Construction, Inc. v. National Union Fire Insurance Company of Pittsburgh*, 651 So.2d 141 (Fla. 3d DCA 1995)(reversal a dismissal based on a no-assignment provision because "a provision against assignment of an insurance policy does not bar an insured's assignment of an after-loss claim"); *Gisela Investments v. Liberty Mutual Ins. Co.*, 452 So.2d 1056 (Fla. 3d DCA 1984)(holding that a "provision in a policy of insurance which prohibits assignment thereof except with consent of the insurer does not apply to prevent assignment of the claim or interest in the insurance money then due, after loss").
[4] 974 So.2d 368, 377 n. 7 (Fla. 2000).

assignment after loss is simply the transfer of the right to a claim for money" and "has no effect upon the insurer's duty under the policy."[5]

Assignments have been prohibited by contract in other insurance contexts. In *Kohl v. Blue Cross Blue Shield of Florida, Inc.*,[6] the court found anti-assignment language was sufficiently clear and upheld language prohibiting the assignment of a health insurance claim. The court explained that anti-assignment clauses "prohibiting an insured's assignments to out-of-network medical providers are valuable tools in persuading health [care] providers to keep their costs down and as such override the general policy favoring the free alienability of choses in action."[7]

Section 627.428, F.S., provides, in part:

> Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which the recovery is had.

This statute allows the insured to recover attorney's fees if the insured prevails in an action against an insurer. A person who takes an assignment of benefits is entitled to attorney's fees if that assignee prevails in an action against an insurer.[8]

Assignment of Benefits in Property Insurance Cases

In recent years, insurers have complained of abuse of the assignment of benefits process. An insurance company recently described the issue in a court filing:

> The typical scenario surrounding the use of an "assignment of benefits" involved vendors and contractors, mostly water remediation companies, who were called by an insured immediately after a loss to perform emergency remediation services, such as water extraction. The vendor came to the insured's home and, before performing any work, required the insured to sign an "assignment of benefits" – when the insured would be most vulnerable to fraud and price-gouging. Vendors advised the insured, "We'll take care of everything for you." The vendor then submitted its bill to the insurer that was, on average, nearly 30 percent higher than comparative estimates from vendors without an assignment of benefits. Some vendors added to the invoice an additional 20 percent for "overhead and profit," even though a general contractor would not be required or hired to oversee the work. Vendors used these inflated invoices to extract higher

[5] *Wehr Constructors, Inc. v. Assurance Company of America*, 384 S.W.3d 680, 683 (Ky. 2012).
[6] 955 So.2d 1140 (Fla. 4th DCA 2007).
[7] *Id.* at 1144-1145.
[8] *See All Ways Reliable Bldg. Maint., Inc. v. Moore*, 261 So.2d 131 (Fla. 1972); *Allstate Insurance Co. v. Regar*, 942 So.2d 969 (Fla.2d DCA 2006).

> settlements from insurers. This, in turn, significantly increases litigation over the vendors' invoices.[9]

In a court filing in a different case, a company that provides emergency repair and construction services explained the rationale behind assignments of insurance benefits:

> As a practical matter, a homeowner often will not be able to afford or hire a contractor immediately following a loss unless the contractor accepts an assignment of benefits to ensure payment. A homeowner may be unable to comply with the… provision requiring the homeowner to protect and repair the premises unless the remediation contractor accepts an assignment of benefits, however, contractors will become unwilling to accept payments by assignment if court decisions render the assignments unenforceable…
>
> Whether the repair invoice is routed through the insured or submitted by the service provider directly by assignment, the service provider's repair invoice is submitted to the insurer for coverage and reviewed by an adjuster. The only difference an assignment makes is that, if an insurance company wishes to partially deny coverage or contest an invoice as unreasonable, the insured policyholder is not mired in litigation in which he or she has no stake.[10]

It is argued that in most cases, assignment of benefits works to the homeowner's advantage because the contractor is in a better position that most homeowners to discuss costs and repair requirements with insurance adjusters.[11]

Proponents of changing the law relating to assignment of benefits argue that the ability to recover attorney's fees under s. 627.428, F.S., leads to more litigation in cases involving assignment of benefits because an assignee can recover full attorney's fees even if the award is small.[12] However, courts have explained that the purpose of s. 627.428, F.S., is to encourage the prompt payment of valid claims and place the insured in the same position he or she would have been had the insurer paid the claim.[13]

Recent Litigation in Cases Involving Assignment of Benefits

Several recent cases have addressed the assignment of post-loss benefits. In *Accident Cleaners, Inc. v. Universal Ins. Co.,*[14] the Fifth District Court of Appeal rejected a claim that s. 627.405, F.S., provided that only a person with an insurable interest at the time of loss could enforce an

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[9] *See Security First Insurance Company v. State of Florida, Office of Insurance Regulation*, Case 1D14-1864 (Fla. 1st DCA), Appellant's Initial Brief at pp. 3-4. (appellate record citations omitted).
[10] *See One Call Property Services, Inc. v. Security First Insurance Company,* Case No. 4D14-0424 (Fla. 4th DCA), Appellant's Initial Brief at 46-48.
[11] Memorandum to Members of the House Insurance and Banking Subcommittee from Dale S. Dobuler, Florida Justice Association (October 26, 2015)(on file with the Committee on Banking and Insurance).
[12] *See* Florida Justice Reform Institute, White Paper: *Restoring Balance in Insurance Litigation***,** (2015) at pp. 9-10. (on file with the Committee on Banking and Insurance.
[13] *See e.g. Travelers Indemnity Insurance Company of Illinois v Meadows MRI, LLP*, 900 So.2d 676, 678-679 (Fla. 4th DCA 2005).
[14] Case No. 5D14-352 (5th DCA April 10, 2015).

insurance contract and held that the right to recover post-loss insurance benefits could be assigned. The court explained that nothing in the statute indicated the Legislature intended to change the "well-settled" law of assignability of contractual rights" or the "inability of insurers to restrict post-loss assignments."

In *One Call Property Services, Inc. v. Security First Ins. Co.*,[15] the Fourth District Court of Appeal explained that even "when an insurance policy contains a provision barring assignment of a policy, an insured may assign a post-loss claim." The court rejected arguments that the insured had nothing to assign at the time the assignment was executed because benefits were not yet due under the policy.[16]

The court explained the competing policy arguments raised by the assignment of benefits issue:

> Turning to the practical implications of this case, we note that this issue boils down to two competing public policy considerations. On the one side, the insurance industry argues that assignments of benefits allow contractors to unilaterally set the value of a claim and demand payment for fraudulent or inflated invoices. On the other side, contractors argue that assignments of benefits allow homeowners to hire contractors for emergency repairs immediately after a loss, particularly in situations where the homeowners cannot afford to pay the contractors up front.[17]

The court noted that if "studies show that these assignments are inviting fraud and abuse, then the legislature is in the best position to investigate and undertake comprehensive reform."[18]

In *Security First Ins. Co. v. State of Florida, Office of Ins. Regulation*,[19] an insurer sought approval from the Office of Insurance Regulation to amend its policy forms to prohibit assignment unless the insurer agreed to the assignment. The Office of Insurance Regulation disapproved the form filing based on Florida court cases holding post-loss benefits are freely assignable.[20] The First District Court of Appeal affirmed the Office of Insurance Regulation's order but noted evidence of abuse of the assignment of benefit process.[21] The court concluded "it is for the legislative branch to consider this public policy problem" and noted that "legislative review provides a more detailed inquiry into the current situation in the industry and greater flexibility in achieving meaningful reform, if deemed necessary."[22]

Data Provided by Insurers

On October 6, 2015, the Insurance Consumer Advocate issued a data call to gather information relating to assignment of benefits. On October 23, 2015, the Office of Insurance Regulation

[15] 165 So.3d 749, 753 (4th DCA 2015).
[16] *Id.* at 754.
[17] *Id*. at 755.
[18] *Id*.
[19] 177 So.3d 627 (Fla. 1st DCA 2015).
[20] *Id.* at 628.
[21] *Id*.
[22] *Id. at* 630.

issued a data call to gather information from insurance companies relating to assignment of benefits and its relationship to property insurance rates. Most insurers did not respond to the Insurance Consumer Advocate data call due to concerns about disclosure of trade secrets. Insurance companies submitted information to the Office of Insurance Regulation during December and January. The office is currently reviewing the information submitted.

Citizens Property Insurance Corporation ("Citizens") provided a summary of information it provided in response to the OIR data call. Citizens randomly sampled 983 claims reported in 2015 that were settled without a lawsuit being filed. The statewide average that Citizens paid for the loss and loss adjustment expense was $15,822 if the claim had an assignment of benefits but $8,507 if the claim did not have an assignment of benefits. If a lawsuit was filed, Citizens paid an average of $37,677 per claim if the claim had an assignment of benefits and $30,526 if the claim did not. In South Florida (Miami-Dade, Broward, and Palm Beach counties), the percentage of claims litigated increased from 15.8 percent in 2010 to 38.4 percent in 2014. Citizens also reported that 31.9 percent of its claimants had representation either by an attorney or public adjuster at the first notice of loss in 2014. That percentage increased to 45.6 percent through the first 9 months of 2015.

III. Effect of Proposed Changes:

This bill creates a new section of law to provide that an agreement that purports to assign or transfer the right to enforce post-loss benefits in a property insurance policy is void. This provision would prevent the assignee from filing an action against the insurance company to enforce payment. Since the assignee could not file an action to enforce payment, the assignee could not collect attorney's fees under s. 627.428, F.S. This bill does not change current law regarding the right of insured to file an action against the insurance company and does not change current law regarding the rights of those who perform home repairs filing actions against homeowners.

This bill requires that all of the following conditions must be met for an assignment agreement to be valid:

- The agreement must authorize a person or entity to be named as a payee or copayee for the benefit of payment as provided in the policy for services rendered and materials provided to mitigate or repair covered damage only.
- The agreement must limit payment to $2,500 per occurrence for work performed to mitigate or repair covered damage.
- The agreement must be provided to the insured's property insurer within 3 business days after execution.
- The agreement must contain an estimate for proposed services and materials to be provided.
- The agreement must allow the insured to cancel the agreement within 3 business days[23] after the agreement is executed or submitted to the insurer, whichever is later. The assignee is entitled to be reimbursed for work already performed before cancellation of the agreement.

[23] The bill extend this period to 5 days if the agreement is executed to perform work resulting from an event for which the Governor has declared a state of emergency and is within 1 year of the declaration.

In addition to providing that an agreement that purports to transfer the right to enforce payment is void, the bill provides that an agreement is void if any of the following conditions are met:

- The agreement imposes an agreement cancellation fee, a mortgage processing fee, or adds an amount for overhead and profit. This addresses concerns that some vendors are inflating the costs and overcharging consumers.[24]
- The final invoice issued under the agreement exceeds the estimated cost for work performed and the increase was not authorized by the insurer.
- The agreement prevents or inhibits an insurer from communicating with the insured at any time. This addresses the problem, reported by some insurers, that assignees are preventing insureds from discussing the claim with the insurance company.
- The agreement purports to transfer or create any authority to adjust, negotiate, or settle any portion of a claim to a person not authorized to adjust, negotiate, or settle a claim under part VI of ch. 626, F.S. This provision prevents a person not licensed as an insurance adjuster from acting as an adjuster.

The agreement must contain the following notice, in 14-point type:

> WARNING: YOU ARE AGREEING TO GIVE UP CERTAIN RIGHTS YOU HAVE UNDER YOUR INSURANCE POLICY TO A THIRD PARTY. PLEASE READ AND UNDERSTAND THIS DOCUMENT BEFORE SIGNING IT. YOU HAVE THE RIGHT TO CANCEL THIS AGREEMENT WITHOUT PENALTY WITHIN 3 BUSINESS DAYS AFTER THE DATE THIS AGREEMENT IS EXECUTED OR WITHIN 3 BUSINESS DAYS AFTER YOUR PROPERTY INSURANCE COMPANY HAS RECEIVED A COPY OF THIS AGREEMENT, WHICHEVER IS LATER. IF WORK IS BEING PERFORMED AS A RESULT OF DAMAGES CAUSED BY AN EVENT FOR WHICH THE GOVERNOR HAS DECLARED A STATE OF EMERGENCY AND IS WITHIN 1 YEAR AFTER SUCH DECLARATION, YOU HAVE 5 DAYS AFTER THE DATE OF EXECUTION TO CANCEL. THIS AGREEMENT DOES NOT CHANGE YOUR DUTIES UNDER YOUR PROPERTY INSURANCE POLICY, SUCH AS PROMPTLY NOTIFYING YOUR INSURANCE COMPANY OF A LOSS AND MITIGATING YOUR PROPERTY FROM FURTHER DAMAGE.

The bill does not apply to a power of attorney granted to a management company, family member, guardian, or similarly situated person which may include the authority to act in place of the principal on property insurance claims. The bill also does not apply to assignments relating to liability coverage in the property insurance policy.

This bill is effective upon becoming a law and its provisions apply to assignments executed after the effective date. The provisions do not apply to agreements entered into before the bill's effective date.

[24] *See* Florida's Assignment of Benefits Problem prepared by American Strategic Insurance (on file with the Committee on Banking and Insurance). It provides examples of charges for mortgage processing fees ranging from $300-$1,500, examples of charges of 10 percent of the total bill for "overhead" and "profit," and cancellation charges of 15 percent-30 percent.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Access to Courts

The bill provides that any assignment that purports to transfer the right to enforce payment for post-loss benefits is void. It could argue that the effect of this bill is to remove the right for an assignee to sue for breach of the insurance contract. The Florida Supreme Court addressed the ability to limit an assignee's access to courts in *Nationwide Mut. Fire Ins. Co. v. Pinnacle Medical Inc.*[25] In that case, Pinnacle, a medical provider, provided medical services to a person injured in an automobile accident. The injured person assigned his rights to receive benefits to Pinnacle. When the insurer refused to pay, Pinnacle, as assignee, brought suit against the insurer for breach of contract. A statute required that a medical provider who had accepted an assignment of benefits must submit to binding arbitration so the insurer argued that Pinnacle could not bring the action.[26]

The court held that the statute prohibiting an assignee from bringing an action to enforce payment violated the Access to Courts[27] provision of the state constitution. The court explained that the right of an assignee to sue for breach of contract to enforce assigned rights predates the Florida Constitution. If a right to seek redress in the courts predates the Florida Constitution, the Legislature cannot abolish that right without providing a reasonable alternative or commensurate benefit unless the Legislature can show an overpowering public necessity for its abolishment and no alternative means of meeting the public necessity.[28]

However, it could be argued that the bill is not impairing access to courts and is a statute restricting assignments. "Generally, causes of action derived from a contract are assignable and contract rights can be assigned unless forbidden by the terms of the contract itself, or unless the assignment would violate some rule of public policy or some

[25] 753 So.2d 55 (2000).
[26] *Id.* at 56.
[27] Art. 1, s. 21, Fla. Const.
[28] *See Pinnacle Medical*, 753 So.2d at 57; *Kluger v. White*, 281 So.2d 1, 4 (Fla. 1973); *Smith v. Department of Insurance*, 507 So.2d 1080, 1088 (Fla. 1987).

statute, or the contract rights involve obligations of a personal nature.[29] Since statutes or public policy are valid reasons for limiting or prohibiting assignments and this bill declares an assignment "void" if it purports to transfer the right to enforce, it can be argued that there is no impairment of access to courts and that the bill is an example of the Legislature declaring by statute the public policy of this state relating to the assignment of benefits of property insurance contracts.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The data provided by Citizens Property Insurance Company indicates that the bill may be effective in lowering property insurance claim costs that are currently associated with an executed post-loss assignment of benefits.

C. Government Sector Impact:

Indeterminate. It is not known whether the changes in this bill will reduce litigation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 627.70133 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.

[29] 3A Fla.Jur.2d Assignments §6; Restatement 2d Contracts 317. *See Kohl v. Blue Cross and Blue Shield of Florida*, 955 So.2d 1140, 1143 (Fla. 4th DCA 2007)(upholding language prohibiting assignments to out of network medical providers).

415826

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Clemens) recommended the following:

Senate Amendment

Delete lines 32 - 49
and insert:
(b) It is provided to the insured's property insurer within 3 business days after execution;
(c) It contains an estimate for proposed services and materials to be provided;
(d) With the exception of reimbursement for work already performed to mitigate or repair covered damage, it allows the


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insured to cancel the agreement, in writing, without penalty or obligation within 3 business days after the date the agreement is executed or within 3 business days after the insurer has been provided with the agreement, whichever is later. However, if the agreement is executed to perform work resulting from an event for which the Governor has declared a state of emergency and is within 1 year after such declaration, the insured has 5 business days after the date the agreement is executed to cancel the agreement without penalty; and

(e) It contains the following notice in 14-point type:

751400

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Banking and Insurance (Clemens) recommended the following:

Senate Amendment

Delete lines 72 - 76
and insert:
(c) It prevents or inhibits an insurer from communicating with the insured at any time; or
(d) It purports to transfer or create any authority to

By Senator Hukill

8-00473C-16 2016596__

A bill to be entitled

An act relating to assignment or transfer of property insurance rights; creating s. 627.70133, F.S.; providing requirements under a property insurance policy for the post-loss assignment or transfer of rights, benefits, or policy provisions not related to liability coverage; providing requirements for an agreement to assign or transfer such rights, benefits, or policy provisions; providing prohibitions and conditions that void such an agreement; providing applicability; providing an effective date.

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

Section 1. Section 627.70133, Florida Statutes, is created to read:

627.70133 Assignment of benefits or transfer of rights.—As to property insurance policies, this section governs the post-loss assignment or transfer of rights, benefits, or policy provisions unrelated to liability coverage to a person or entity other than the named insured. This section does not affect the post-loss assignment or transfer of rights, benefits, or other policy provisions related to liability coverage in the property insurance policy.

(1) An agreement entered into under this section to assign or transfer rights, benefits, or policy provisions is not valid unless:

(a) It authorizes a person or entity to be named as a payee or copayee for the benefit of payment as provided in the policy

8-00473C-16 2016596__

for services rendered and materials provided to mitigate or repair covered damage only;

(b) It is limited to $2,500 per occurrence for work performed to mitigate or repair covered damage;

(c) It is provided to the insured's property insurer within 3 business days after execution;

(d) It contains an estimate for proposed services and materials to be provided;

(e) With the exception of reimbursement for work already performed to mitigate or repair covered damage, it allows the insured to cancel the agreement, in writing, without penalty or obligation within 3 business days after the date the agreement is executed or within 3 business days after the insurer has been provided with the agreement, whichever is later. However, if the agreement is executed to perform work resulting from an event for which the Governor has declared a state of emergency and is within 1 year after such declaration, the insured has 5 business days after the date the agreement is executed to cancel the agreement without penalty; and

(f) It contains the following notice in 14-point type: WARNING: YOU ARE AGREEING TO GIVE UP CERTAIN RIGHTS YOU HAVE UNDER YOUR INSURANCE POLICY TO A THIRD PARTY. PLEASE READ AND UNDERSTAND THIS DOCUMENT BEFORE SIGNING IT. YOU HAVE THE RIGHT TO CANCEL THIS AGREEMENT WITHOUT PENALTY WITHIN 3 BUSINESS DAYS AFTER THE DATE THIS AGREEMENT IS EXECUTED OR WITHIN 3 BUSINESS DAYS AFTER YOUR PROPERTY INSURANCE COMPANY HAS RECEIVED A COPY OF THIS AGREEMENT, WHICHEVER IS LATER. IF WORK IS BEING PERFORMED AS A RESULT OF DAMAGES CAUSED BY AN EVENT FOR WHICH THE GOVERNOR HAS DECLARED A STATE OF EMERGENCY AND IS WITHIN 1

YEAR AFTER SUCH DECLARATION, YOU HAVE 5 DAYS AFTER THE DATE OF EXECUTION TO CANCEL. THIS AGREEMENT DOES NOT CHANGE YOUR DUTIES UNDER YOUR PROPERTY INSURANCE POLICY, SUCH AS PROMPTLY NOTIFYING YOUR INSURANCE COMPANY OF A LOSS AND MITIGATING YOUR PROPERTY FROM FURTHER DAMAGE.

(2) An agreement is void if:

(a) It imposes an agreement cancellation fee, a check processing fee, or a mortgage processing fee or adds an amount for overhead and profit to the amount for mitigation and repair of covered property;

(b) A final invoice issued under the agreement exceeds the estimated cost for work performed and the increase in cost was not authorized by the insurer;

(c) It purports to assign or transfer the right to enforce payment for post-loss benefits in the policy;

(d) It prevents or inhibits an insurer from communicating with the insured at any time; or

(e) It purports to transfer or create any authority to adjust, negotiate, or settle any portion of a claim to a person or entity who is not authorized to adjust, negotiate, or settle a claim on behalf of the insured or claimant under part VI of chapter 626.

(3) This section does not apply to a power of attorney granted to a management company, family member, guardian, or similarly situated person which complies with chapter 709 and which may include, as part of the authority granted, the authority to act in place of a principal as it relates to a property insurance claim.

Section 2. This act applies to post-loss assignments or

transfers of rights, benefits, or policy provisions not related to liability coverage which are executed after the effective date of this act.

Section 3. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR DOROTHY L. HUKILL
8th District

COMMITTEES:
Finance and Tax, *Chair*
Communications, Energy, and Public Utilities, *Vice Chair*
Appropriations
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Banking and Insurance
Fiscal Policy

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

November 4, 2015

The Honorable Lizbeth Benacquisto
320 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399

Re: Senate Bill 596 – Assignment or Transfer of Property Insurance Rights

Dear Chairwoman Benacquisto:

Senate Bill 596, relating Assignment or Transfer of Property Insurance Rights has been referred to the Banking and Insurance Committee. I am requesting your consideration on placing SB 596 on your next agenda. Should you need any additional information please do not hesitate to contact my office.

Thank you for your consideration.

Sincerely,

Dorothy L. Hukill, District 8

cc: James Knudson, Staff Director of the Banking and Insurance Committee
Sheri Green, Administrative Assistant of the Banking and Insurance Committee

REPLY TO:
❒ 209 Dunlawton Avenue, Unit 17, Port Orange, Florida 32127 (386) 304-7630 FAX: (888) 263-3818
❒ Ocala City Hall, 110 SE Watula Avenue, 3rd Floor, Ocala, Florida 34471 (352) 694-0160

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

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 650
INTRODUCER:	Banking and Insurance Committee and Senator Legg
SUBJECT:	Viatical Settlements
DATE:	January 27, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Knudson	BI	**Fav/CS**
2.			AGG	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 650 amends the Viatical Settlement Act, ss. 626.991 – 626.99295, F.S. A viatical settlement contract is a written agreement entered into between the owner of a life insurance policy, referred to as the viator, and a viatical settlement provider wherein the viator agrees to transfer ownership or change the beneficiary designation of a life insurance policy at a later date in exchange for compensation paid to the viator. The compensation paid to the viator is generally less than the expected death benefit under the policy. Rather than retaining the policy, the provider usually sells all or part of the policy to one or more investors. In return for providing funds, these investors receive the death benefit, or a proportionate share thereof, upon the passing of the insured.

The bill provides greater specificity regarding fraudulent, deceptive, and prohibited practices that are subject to administrative sanctions by the Office of Insurance Regulation (OIR) and felony criminal sanctions. The bill does this by defining actions that constitute "fraudulent viatical settlement acts;" and including their commission as prohibited practices under ss. 626.99275 and 626.9914, F.S.

The bill makes engaging in a stranger-originated life insurance (STOLI) practice a felony fraudulent viatical settlement act and makes STOLI contracts void and unenforceable. Stranger-originated life insurance is somewhat similar to a viatical transaction, with the key difference that the individual who obtains a life insurance policy does so for the express purpose of assigning the policy in exchange for compensation, thus violating Florida law requiring

beneficiaries to have an insurable interest in the life of the policyholder. In a proper viatical settlement, the insurance policy was originally purchased with the intent that benefits would be paid to persons or entities with an insurable interest – a reasonable expectation of a monetary benefit from the continued well-being of the life being insured.

The bill increases from $2,500 to $10,000 the maximum fines the OIR may impose for each nonwillful violation of the Viatical Settlement Act, and increases from $10,000 to $25,000 the maximum fine for each willful violation of the Act.

The bill increases the contestability period for viatical settlement agreements from 2 years to 5 years. Florida law prohibits the creation of a viatical settlement contract during the contestability period unless the viator certifies that he or she meets an exception that justifies viatication of the policy. The bill specifies that the viator must, to claim an exception, execute a sworn affidavit and document that an exception applies. Such exceptions include, but are not limited to, the viator is terminally or chronically ill, is retired, has a disability preventing full-time employment, experienced the divorce or death of a spouse, or the owner of the policy is not a natural person. The bill allows viatication after 2 years if prior to the issuance date of the policy: premiums were funded with unencumbered assets, no agreement to sell the policy was made, and the insured and the policy were not evaluated for settlement.

The bill also:

- Establishes new disclosure and annual reporting requirements and conflicts of interest prohibitions for viatical service providers;
- Requires viatical service providers to file their advertising and marketing materials with the OIR prior to entering into viatical contracts;
- Requires viatical service providers maintain documentation of compliance with their anti-fraud plans; and
- Requires viatical service providers to provide certain documentation to insurers for verification of coverage, prior to entering into a viatical settlement contract.
- Increases the deposit requirement for viatical settlement providers from $100,000 to $250,000.

The effective date of the bill is July 1, 2016.

II. Present Situation:

Life Insurance – Insurable Interests

A fundamental concept in life insurance is that the purchaser and beneficiary of an insurance policy must have an insurable interest—a reasonable expectation of a monetary benefit from the continued well-being of the life being insured. In the context of life insurance, the insurable interest prevents purchasing insurance as a form of gambling on the death of the insured, which creates a moral hazard for the purchaser who may be tempted create a situation where he or she will be able to collect on the policy.

The insurance interest requirement for life insurance can be found in the Florida Statutes at s. 627.404, F.S. Florida law prohibits the procurement of "an insurance contract on the life or

body of another individual unless the insurance contract benefits are payable to the insured, his or her personal representatives, a person having an insurable interest in the insured when the contract was made.[1]" Persons with insurable interest include the insured, family members and loved ones of the insured, others if the insured's life and health is of greatest benefit to them, trusts and trustees in specified circumstances, charitable organizations, and business organizations in specified circumstances.

Viatical Settlement Contracts - Background

A viatical settlement contract is a written agreement entered into between the owner[2] of a life insurance policy, referred to as the viator, and a viatical settlement provider wherein the viator agrees to transfer ownership or change the beneficiary designation of a life insurance policy at a later date in exchange for compensation paid to the viator.[3] The compensation paid to the viator is generally less than the expected death benefit under the policy. Rather than retaining the policy, the provider usually sells all or part of the policy to one or more investors. In return for providing funds, these investors receive the death benefit, or a proportionate share thereof, upon the passing of the insured.

Viatical settlements emerged during the HIV/AIDS epidemic in the 1980s, enabling terminally ill patients with short life expectancies who could no longer work and afford the policy premiums to sell their life insurance policies at a cash discount to pay for high medical care expenses. In the early days of the epidemic, AIDS patients generally died within months of their diagnoses, resulting in fairly quick, significant returns to investors,[4] who in those days were typically senior individuals who risked their savings in what was represented as a safe investment and marketed as a compassionate way to help dying patients. However, innovations in AIDS treatment in the early 1990s significantly improved life expectancies of AIDS patients, sometimes even outliving their investors, which disrupted mortality assumptions and diminished investor returns.

Two consequences resulted from the insureds of viaticated policies exceeding their life expectance. The first is that some viatical settlement providers stopped brokering new viatical settlements. The second, unfortunately, is that some viatical settlement providers engaged in fraudulent practices.[5]

An example cited by the Office of Insurance Regulation of such fraudulent activity was Mutual Benefits Corporation.[6] In 2004, the OIR suspended MBC's license and the United States Securities and Exchange Commission (SEC) filed an action in federal court seeking an injunction and the appointment of a receiver. The court-appointed receiver reported that MBC had fraudulently procured insurance policies with a total face value of approximately $1.4 billion. The SEC agreed to a $25 million settlement and referred the case to prosecutors.

[1] The insurable interest need not exist after the inception date of coverage under the contract.
[2] Or certificateholder if a group policy.
[3] s. 626.9911, F.S.
[4] Kelly J. Bozanic, *An Investment to Die For: From Life Insurance to Death Bonds, the Evolution and Legality of the Life Settlement Industry*, 113 PENN. ST. L. REV. 229, 233-234 (2008).
[5] Office of Insurance Regulation, *Secondary Life Insurance Market Report to the Florida Legislature* (Dec. 2013), p. 9.
[6] *See* Office of Insurance Regulation, *supra* note 5, at pg. 10.

Federal prosecutors charged former company employees, most of whom have pled guilty and were sentenced to lengthy prison terms. A factual statement filed by an MBC employee described the scheme. Mutual Benefits Corporation would falsely promise investors a fixed rate of return but was unable to keep those promises because insureds lived longer than expected and their premiums had to be paid to keep the underlying policies in force. New investor sales were used to continue to pay premiums on the previously viaticated life insurance policies. The MBC experience and other fraudulent schemes led to the Legislature comprehensively reforming the regulation of the viatical settlement industry in 2005.

Today, the viatical settlement market is not limited to the purchase of the life insurance products of the terminally ill. Viatical settlement contracts are also entered into with non-terminally ill insureds that no longer want, need, or can afford their policies. These agreements, often referred to as life settlements, serve as an alternative to exercising a redemption or accelerated death benefit clause in life insurance policies.

Regulation of the Viatical Settlement Industry

Viatical settlement providers and viatical settlement brokers are required to obtain licensure from the Office of Insurance Regulation. The Viatical Settlement Act (Act)[7] sets forth requirements for licensure, annual reporting, disclosures to viators, transactional procedures, adoption of anti-fraud plans, and administrative, civil, and criminal penalties. The Act also provides the OIR with examination and enforcement authority over viatical service providers and brokers; review and approval authority over the viatical settlement contracts and forms; rulemaking authority; and provided that a violation of the Act is an unfair trade practice under the Insurance Code. The Act does not authorize the OIR to regulate the rate or amount paid as consideration for a viatical settlement contract.[8]

In 2005, legislation was enacted that requires the investment transaction to be regulated as a security under ch. 517, F.S. These investments must be registered with either the Office of Financial Regulation (OFR) or the federal Securities and Exchange Commission. In addition, persons offering such investments must obtain licensure from the OFR and provide full and fair disclosures concerning viatical settlement investments to prospective investors. The 2005 legislation also provides that a person or firm who offers or attempts to negotiate a viatical settlement between an insured (viator) and a viatical service provider for compensation is a *viatical settlement broker* who must be licensed with the Department of Financial Services (DFS) as a life insurance agent with a proper appointment from a viatical service provider. Viatical settlement brokers owe a fiduciary duty to the viator.[9]

In 2013, the Legislature directed the OIR to review Florida law and regulations to determine whether there were adequate protections for purchasers of life insurance policies in the secondary life insurance market.[10] Following a public hearing conducted by the OIR, in which both life insurers and institutional investors participated, the OIR published a report, concluding

[7] Ch. 96-336, Laws of Fla.
[8] s. 626.9926, F.S.
[9] ss. 626.9911(9) and 626.9916, F.S.
[10] Ch. 2013-40, s. 6, Laws of Fla. (2013 General Appropriations Act, p. 316).

that adequate protections for institutional purchasers in the secondary life insurance market existed and that their recommendations did not warrant legislative action at the time.[11]

Stranger-Originated Life Insurance

Stranger-originated life insurance (STOLI) is somewhat similar to a viatical transaction, but with the key difference that the individual who obtains a life insurance policy does so for the express purpose of assigning the policy in exchange for compensation. In a typical STOLI transaction, an individual (usually a senior) is encouraged to take out insurance on his or her own life, sometimes in the millions of dollars, and then assigns the policy to an investor or group of investors (the "stranger") who pay the individual a large cash settlement in exchange for the ownership rights to the policy, including the right to receive the proceeds upon the insured's death.

Stranger-originated life insurance may appear similar to a viatical or life settlement. The critical difference is that in viatical or life settlements, an insured initially buys life insurance in a good-faith intent to protect valid insurable interests (i.e., to protect family members or a business from the risk of a premature death), but subsequently decides to sell the policy to a third party due to a change in circumstances that may not warrant the policy (such as divorce, death of an intended beneficiary, or the need for immediate cash due to illness or other loss). In a STOLI, the policy is intentionally purchased for the benefit of persons (usually investors) who lack an insurable interest at the time the life insurance contract is entered into. These investors ultimately receive the proceeds, directly or indirectly.[12] The Uniform Law Commission has noted that the beneficiaries of STOLI transactions argue that it is an appropriate use of life insurance consistent with applicable legal principles, including the free transferability of assets. Life insurers oppose the use of STOLI, arguing that it is a perversion of the concept of life insurance and leads to the moral hazard concerns that insurable interest doctrines are intended to mitigate.[13]

Transactions involving STOLI often use fraudulent means to procure life insurance on individuals, such as misrepresentation, falsification, or omission of material facts in the life insurance application. The fraud is conducted so that an assignment or sale of a policy functions as a subterfuge that circumvents the insurable interest requirement. STOLI transactions generally target senior citizens and are often financed through non-recourse "premium finance loans." It is common for STOLI to be structured through the use of an irrevocable trust, which conceals from the life insurance company that the policy was sold. The insured pays premiums during the contestable period to prevent the insurer from discovering a possible violation of the insurable interest requirement.

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[11] *See* Office of Insurance Regulation, *supra* fn. 5, pp. 50-51.
[12] AALU, NAIFA, and ACLI, *STOLI: The Problem and the Appropriate State Response*, p. 4, (on file with the Senate Committee on Banking and Insurance).
[13] UNIFORM LAW COMMISSION, *Insurable Interest Amendment to the Uniform Trust Code Summary*, at http://www.uniformlaws.org/ActSummary.aspx?title=Insurable%20Interests%20Amendment%20to%20the%20Uniform%20Trust%20Code (last visited Jan. 13, 2016).

According to the OIR, STOLI impacts consumers (both individual investors and insureds) and insurers in a number of ways:[14]

- Seniors may exhaust their life insurance purchasing capability and not be able to protect their own family or business.
- The incentives, especially cash payments, used to lure seniors to participate in STOLI schemes are taxable as ordinary income.
- Seniors may subject themselves or their estates to potential liability in the event the life insurance policy is rescinded by an insurer who discovers fraud.
- Seniors may encounter unexpected tax liability from the sale of the life insurance policy.[15]
- The "free" insurance is not free and may be subject to tax based on the economic value of the coverage.
- Seniors have to give the purchaser, and subsequent purchasers, access to their medical records when they sell their life insurance policy in the secondary market so that investors know the health status of the insured. The investors want to know the "status" of their investment and how close they are to getting paid.
- STOLI may lead to an increase in life insurance rates for the over-65 population.
- If STOLI practices continue to proliferate, the U.S. Congress may remove the tax-free status of life insurance proceeds.

Over 30 states currently prohibit STOLI, generally through some combination of the NAIC and NCOIL model acts, in addition to common law or statutory insurable interest laws. STOLI has resulted in significant litigation, criminal and regulatory enforcement actions, both nationally and in Florida.[16]

The OIR may use several legal or regulatory remedies to address STOLI transactions. The Viatical Settlement Act authorizes the OIR to impose fines of up to $2,500 for nonwillful violations and up to $10,000 for willful violations, or to suspend, revoke, deny, or refuse to renew the license of any viatical settlement provider found to be engaging in certain acts, such as fraudulent or dishonest practices, dealing in bad faith with viators, or violating any provision of the Act or the Insurance Code. The OIR may also impose cease and desist orders and immediate final orders for violations of the Act.[17]

Currently, s. 627.409, F.S., provides that misrepresentation, omission, concealment of fact, or incorrect statements on an application for an insurance contract "may prevent recovery" in certain cases, however, there are no criminal penalties and an action for rescission by the life insurer is the only civil penalty available. Various provisions of the Insurance Code authorize the DFS to suspend or revoke the license or appointment of licensees, agencies, or appointees on various grounds, such as using fraudulent or dishonest practices in the conduct of business under

[14] Office of Insurance Regulation, 2016 Agency Legislative Bill Analysis of SB 650, pg. 6 (Nov. 5, 2015); Additionally, s. 626.9923, F.S., requires viatical service providers to disclose certain risks to viators, such as tax and Medicaid eligibility consequences.
[15] *See* IRS Rev. Ruls. 09-13 and 09-14, regarding taxation of proceeds from settlements as capital gains ordinary income and taxation on a post-settlement basis.
[16] For a listing of OIR enforcement actions, see OIR, *Viatical Criminal, Civil and Regulatory Actions*, http://www.floir.com/sections/landh/viaticals/ccr_actions.aspx (last visited Jan. 23, 2016) and 2013 OIR Report, *Appendix C: Florida Regulatory and Enforcement Actions Pertaining to Viatical Settlement Providers*.
[17] ss. 626.9914 and 626.99272 , F.S.

the license.[18] Finally, the Unfair Insurance Trade Practices Act in s. 626.9541, F.S., lists several unfair methods of competition and unfair or deceptive acts or practices. Each violation of this statute can result in fines ranging from $5,000 to $75,000, depending on the willfulness and particular violation. In addition, "twisting" and "churning" are first-degree misdemeanors, while willfully submitting false signatures on an application is a third-degree felony.[19] The OIR believes that though viatical settlement providers are subject to this statute by way of s. 626.9927, F.S., and STOLI transactions do share some components of these practices, the statute was written for the initial sale of an insurance policy to an insured and not specifically for STOLI, making it difficult and unwieldy for the OIR to apply the provisions to secondary sales of life insurance policies.[20]

Life insurers engage in insurable interest litigation to combat STOLI, usually relying on the insurable interest statute in s. 627.404, F.S., to rescind the policies transferred in a STOLI transaction for a lack of insurable interest when the policy was initially entered into. This argument is sometimes opposed with arguments seeking the application of the incontestability statute, s. 627.455, F.S., which requires life insurance policies to include a provision barring the insurer from challenging the policy after it is in force for 2 years.

In separate cases, the U.S. District Court for the Southern District of Florida reached different interpretations on the interplay of these statutes.[21] These appeals were consolidated to the U.S. Court of Appeals for the Eleventh Circuit, which noted that there are no cases decided by Florida courts that specifically address whether a party can challenge an insurance policy as being void ab initio for lack of an insurable interest if the challenge is made after the 2-year contestability period, and if so, whether the individual with the required insurable interest must procure the policy in good faith. As a result, the Eleventh Circuit certified questions to the Florida Supreme Court last year for a determination of Florida law on the conflict between these two statutes.[22]

Current law does not specifically define STOLI, nor does it have a specific regulatory prohibition on STOLI or life insurance policies lacking an insurable interest at inception.

III. Effect of Proposed Changes:

Fraudulent Viatical Settlement Acts – Definition; Criminal and Administrative Penalties

CS/SB 650 provides greater specificity regarding fraudulent, deceptive, and prohibited viatical settlement practices that are subject to administrative and felony criminal sanctions. The bill does this by defining actions that constitute "fraudulent viatical settlement acts;" and including their commission as prohibited practices under ss. 626.99275 and 626.9914, F.S. The bill specifically defines a stranger-originated life insurance (STOLI) practice as a fraudulent viatical settlement act and makes STOLI contracts void and unenforceable.

[18] ss. 626.611, 626.6115, 626.6215, and 626.621, F.S.
[19] s. 626.9541, F.S.
[20] OIR Agency Analysis, p. 2.
[21] *Pruco Life Ins. V. Brasner*, 2011 WL 134056 (S.D. Fla. Jan. 7, 2011), and *Pruco Life Ins. Co. v. U.S. Bank*, 2013 WL 4496506 (S.D. Fla. Aug. 20, 2013).
[22] *Pruco Life Ins. Co. v. Wells Fargo Bank, N.A.*, 780 F.3d 1327 at 1336 (11th Cir. C.A. 2015). The appeal, currently pending at the Florida Supreme Court (Case No. SC15-382), is scheduled for oral argument on March 10, 2016, and will go back to the Eleventh Circuit for final disposition.

Section 1 amends s. 626.9911, F.S., to define "fraudulent viatical settlement act" to mean an act or omission committed by a person who, knowingly or with the intent to defraud for the purpose of depriving another of property for pecuniary gain, commits or allows an employee or agent to commit the following acts:

- Presenting[23] false or concealed material information as part of, in support of, or concerning a fact material to a viatical settlement contract or insurance policy.
- Employing a plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies.
- Engaging in a stranger originated life insurance practice.
- Failing to disclose upon request by an insurer that the prospective insured has undergone a life expectancy evaluation by a person other than the insurer or its authorized representatives in connection with the issuance of the policy.
- Perpetuating a fraud or preventing its detection.
- Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or other person engaged in the business of viatical settlements or insurance.
- Recklessly entering into, negotiating, brokering or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained on false information intended to defraud. "Recklessly" means acting or failing to act in conscious disregard for relevant facts or risks, involving a gross deviation from acceptable standards of conduct.
- Facilitating the viator's change of residency to avoid the provisions of the Act.
- Facilitating or causing the creation of a trust with a non-Florida situs or other nonresident entity for the purpose of owning a life insurance policy covering a Florida resident to avoid the Act.
- Facilitating or causing the transfer of the ownership of an insurance policy covering a Florida resident to a trust with a non-Florida situs or other nonresident entity to avoid the provisions of the Act.
- Applying for or obtaining a loan that is secured, directly or indirectly, by an interest in a life insurance policy.
- Violating s. 626.99273(1) or (2), F.S., which are created by the bill. The prohibited action under subsection (1) is knowingly soliciting an offer from, effectuating a viatical settlement with, or making a sale to any viatical settlement provider, financing entity, or related provider trust that is controlling, controlled by or under common control with the viatical settlement provider. The prohibited action under subsection (2) is knowingly entering into a viatical settlement with a viator if anything of value will be paid to a viatical settlement broker that controls, is controlled by, or under common control with the viatical settlement provider, financing entity, or related provider trust that is involved in the viatical settlement.
- Attempting to commit, assisting, aiding, or abetting in the commission of or conspiring to commit a fraudulent viatical settlement act.

Section 3 amends s. 626.9914, F.S., making viatical settlement providers that commit fraudulent settlement acts subject to license suspension, revocation, denial, or nonrenewal by the OIR. The

[23] Under the bill, presenting includes causing false information to be presented concerning material facts, or preparing false information concerning material facts with the knowledge or belief that the information will be presented to or by another person.

OIR also has authority to assess administrative fines in lieu of or in addition to a suspension or revocation, and also may place an existing licensee on probation for 2 years or less.

Section 9 amends s. 626.99275, F.S., making it unlawful to engage in a fraudulent viatical settlement act. Violations of s. 626.99275, F.S., are punishable as a third degree felony of the insurance policy involved is valued at less than $20,000; a second degree felony if the insurance policy involved is valued at $20,000 or more but less than $100,000; or a first degree felony if the insurance policy involved is valued at $100,000 or more.

Stranger-originated Life Insurance – Definition; Criminal and Administrative Penalties

The bill defines stranger-originated life insurance (STOLI) practices and makes void and unenforceable contracts and agreements for the furtherance or aid of a STOLI practice. STOLI practices are included as fraudulent viatical settlement acts by the bill and thus are punishable as felonies under s. 626.99275, F.S., and such practices subject viatical settlement providers that commit them to fines and either probation or license suspension, revocation, denial or nonrenewal under s. 626.9914, F.S.

Section 1 amends s. 626.9911, F.S., defining a "stranger-originated life insurance practice" (STOLI) to mean the initiation of a life insurance policy for the benefit of a third-party investor who has no insurable interest in the insured at the time of policy origination. Two examples of a STOLI practice are provided. The first is the purchase of a life insurance policy with resources or guarantees from a person who could not lawfully initiate the policy and the execution of an agreement to transfer ownership of the policy to a third party. The second example is the creation of a trust that appears to have insurable interest to initiate policies for investors that violates insurable interest laws and the prohibition against wagering on life.

Stranger-originated life insurance practices are included within the definition of "fraudulent viatical settlement acts" created in this section. Accordingly, **Section 9** provides that STOLI practices are punishable as felonies under s. 626.99275, F.S., and **Section 3** subjects viatical settlement providers that commit them to fines and either license probation or license suspension, revocation, denial or nonrenewal under s. 626.9914, F.S.

Section 13 creates s. 626.99289, F.S., making void and unenforceable contracts, agreements, arrangements, and transactions entered into verbally or in writing, for the furtherance or aid of a STOLI practice. Such contracts include, but are not limited to, financing agreements or other arrangements that facilitate a STOLI practice.

Section 9 includes as a felony prohibited practice knowingly issuing, soliciting, marketing, or promoting the purchase of a life insurance policy for the purpose of, or with an emphasis on, selling the policy.

Viatical Settlement Act – Grounds for Administrative Action against Licensee and Maximum Fines

Section 3 of the bill amends s. 626.9914(2), F.S., to increase from $2,500 to $10,000 the maximum fines the OIR may impose for each nonwillful violation of the Viatical Settlement Act,

and increases from $10,000 to $25,000 the maximum fine for each willful violation of the Act. The OIR continues to have authority to levy such fines in lieu of or in addition to any suspension or revocation of licensure, and to place a licensee on probation for not more than 2 years in lieu of suspension, revocation, or nonrenewal.

The section also specifies that it is grounds for license probation or suspension, revocation, denial or nonrenewal for licensee to contract with a person who materially influences the licensee's conduct and who fails to meet the requirements of the Act. This expands current law, which requires the OIR to take action against a licensee that employs a person who materially influences the licensee's conduct and fails to meet the requirements of the Act.

Viatical Settlement Provider Licensee Annual Statement

Section 2 amends s. 626.9913, F.S., to increase the deposit requirement for viatical settlement provider licensees from $100,000 to $250,000.

The bill also specifies disclosures that a viatical settlement provider must make in its annual statement. Current law requires each viatical settlement provider licensee to provide an annual statement to the Office and pay a $500 license fee on or before March 1. The bill requires the annual statement to specify the total number of unsettled viatical settlement contracts and the corresponding total amount due to viators, categorized by the number of days since the viator signed the contract for transactions regulated by the state. The annual statement must also specify, for the most recent 5 years, the total number of policies purchased, the total gross amount paid for the purchased policies, and the total face value of such policies, allocated by state, territory, and jurisdiction. Finally, the annual statement must specify the total amount of proceeds or compensation paid to policyowners, allocated by state, territory, and jurisdiction.

The bill provides the OIR rulemaking authority to implement s. 626.9913, F.S.

Mandatory Disclosures to Viator

Section 5 creates s. 626.99185, F.S., which requires the viatical settlement provider to provide to the viator a written disclosure, in duplicate, which must be signed by the viator before, or concurrently with, the execution of a viatical settlement contract or an amendment to the contract. The disclosure must name each viatical settlement broker that receives compensation and the amount of compensation each receives. The disclosure must also contain a complete reconciliation of the gross offer or bid by the viatical settlement provider to the net proceeds or value to be received by the viator related to the transaction. The gross offer is the total amount offered by the viatical settlement provider for the purchase of an interest in one or more life insurance policies, including commissions, compensation or other proceeds being deducted from the gross offer.

If the contract is subsequently amended or a change in the gross offer, the net proceeds to be received by the viator, or a change in the information provided in the disclosure statement, an amended disclosure statement must be provided by the viatical settlement provider and signed and dated by the viator.

Disclosure documentation must be maintained by the viatical settlement provider and made available to the OIR upon reasonable notice to the provider.

Prohibited Conflicts of Interest; Prohibition against Representing that Insurance is Free; Submission of Advertising Material to the OIR

Section 8 creates s. 626.99273, F.S., which prohibits viatical settlement providers and brokers from engaging in specified practices and conflicts of interests.

The following are the prohibited conflicts of interest:

- A viatical settlement broker is prohibited from knowingly soliciting an offer, effectuating a viatical settlement, or making a sale to a viatical settlement provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with the broker.
- A viatical provider may not knowingly enter into a viatical settlement with a viator if, in connection with the settlement, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with the settlement provider, financing entity, or related provider trust involved with the settlement.

The following are the prohibited acts:

- A viatical settlement provider may not enter into a viatical settlement contract unless the promotional, advertising, and marketing materials have been filed with the office. The materials may not cause a viator to reasonably believe that the life insurance is free for any period of time.
- A life insurance producer, insurer, viatical settlement broker or viatical settlement provider may not make a statement or representation to an applicant or policyholder in connection with the sale of a life insurance policy to the effect that the insurance is free for any period of time.

The bill provides rulemaking authority to the OIR to administer s. 626.99273, F.S.

Prohibited Practices

Section 9 amends s. 626.99275, F.S., to specify additional prohibited practices under the Act. Under current law and the bill, engaging in a practice prohibited by this section is a felony offense.

The bill prohibits knowingly entering into a viatical settlement contract in two circumstances. The first is entering into a viatical settlement before the application for, or issuance of, a life insurance policy. This is essentially a prohibition on STOLI transactions where the life insurance is purchased for the benefit of a person or entity without an insurable interest. The second prohibition is against entering into a viatical settlement contract during the 5-year contestability period unless the viator provides a sworn affidavit and accompanying documentation pursuant to s. 626.99287, F.S. (Section 12 of the bill increases the contestability period for viatical settlement agreements from 2 years from the issuance of the life insurance policy to 5 years from the issuance of the policy and requires documentation that the exception applies).

The bill also prohibits knowingly issuing, soliciting, marketing, or promoting the purchase of a life insurance policy for the purpose of or with an emphasis on selling the policy. This provision is intended to prohibit such practices where the emphasis is on the purchaser of the policy subsequently selling the policy, essentially encouraging a STOLI practice.

The bill also makes engaging in a fraudulent viatical settlement act a prohibited practice. Section 1 of the bill defines fraudulent viatical settlement acts. The various acts that constitute a viatical settlement act are discussed earlier in this analysis under the subheading "Fraudulent Viatical Settlement Acts – Definition; Criminal and Administrative Penalties."

Extension of the Contestability Period during Which Viatical Contracts are Prohibited

Section 12 amends s. 626.99287, F.S., which contains the contestability requirements for viaticated life insurance contracts. Generally, a life insurance policy cannot be viaticated during the contestability period and such viatical settlement contracts are void and unenforceable. The bill expands the contestability period for viaticaled life insurance contracts from 2 years to 5 years. A viatical settlement contract may be entered into during the contestability period, however, under various exemptions, one of which is the execution by the viator of a sworn affidavit certifying that certain conditions such as the diagnosis of a life threatening illness or the death of a spouse have occurred. The bill provides that in order for an exception to be claimed the viator must provide a sworn affidavit that one of the exemptions apply.

The bill also revises two of the existing exceptions. The exception for a life insurance policy issued upon the owner's exercise of conversion rights arising out of a group or term policy is limited by the bill to instances when the total time covered under the prior policy is at least 60 months. Conversion occurs when the insured converts life insurance under a group policy to an individual policy, often because the insured has lost the group policy. The exception for illness is changed and under the bill requires the viator to be "terminally or chronically ill." Currently this exception requires a diagnosis of an illness or condition that is catastrophic, life threatening, or requires a course of treatment of at least 3 years or home health care.

The bill retains the 2 year contestability period if three conditions are met. The first condition is that policy premiums were funded exclusively with unencumbered assets which may include an interest in the policy being financed but only to the extent of the net cash surrendered value provided by or full recourse liability incurred by the insured. The second condition is that during the 2 years, an agreement was not entered into to guarantee the insured's full recourse liability or to purchase the policy. The third condition is that the insured and the policy were not evaluated for settlement.

Required Notification to the Insurer of Execution of Sworn Affidavit Allowing a Viatical Settlement Contract during the Contestability Period

Section 10 creates s. 626.99276, F.S., to require that a copy of the sworn affidavit and documentation required to viaticate a policy during a contestability period to be submitted to the insurer if:

- The a party entering into a viatical settlement contract with a viator submits a request to the insurer for verification of coverage or

- The viatical settlement provider submits a request to the insurer to transfer the policy to the provider.

A viatical settlement provider must also execute and provide a sworn affidavit that the copy of the viator's sworn affidavit is a true and correct copy. The bill prohibits the insurer from requiring as a condition of verifying coverage or transferring a contract the viator, insured or viatical settlement provider execute a signed disclosure, consent form, waiver form or other form that is not approved by the OIR for use in connection with viatical settlement contracts. The insurer must, within 30 days of receiving a properly completed request for change of ownership or beneficiary of coverage, respond in writing confirming the change or specifying why the requested change cannot be processed.

Documentation of Viatical Provider Anti-Fraud Plans and Procedures

Section 11 amends s. 626.99278, F.S., to require each licensed viatical settlement provider to maintain documentation of compliance with its anti-fraud plan and procedures, resolved and unresolved material inconsistencies between medical records and insurance applications, and mandatory reporting to the Division of Insurance Fraud of possible fraudulent acts and prohibited practices specified in s. 626.99275, F.S.

Definitions

Section 1 defines "business of viatical settlements" to include numerous activities involved in the acquisition of an interest in a life insurance policy by means of a viatical settlement contract. The activities include offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypothecating, or acquiring in other manner, an interest in a life insurance policy via a viatical settlement contract. The definition broadly defines "business of viatical settlements" for the purpose of applying the requirements of the Viatical Settlement Act to a wide-array of business practices related to viatical settlements.

Clarifies that provisions regarding a "related form" apply to an insured, as well as the viator.

The term "viatical settlement contract" is amended to include the transfer for compensation or value of an ownership or beneficial interest in a trust or other entity that owns a life insurance policy if the trust or entity was formed or used for the principal purpose of acquiring life insurance contracts that insure the life of a Florida resident. The definition is revised to facilitate the application of the Viatical Settlement Act to trusts that engage in such actions. The bill also clarifies that the term does not include accelerated death provisions in life insurance policies, loans secured by the cash surrender value of a policy, or loans from the issuer of the policy to the policyholder.

The term "viatical settlement provider" is amended to include licensed lending institutions (other than banks, savings banks, savings and loan associations, or credit unions) that take an assignment of a life insurance policy as collateral for a loan.

The bill also defines "fraudulent viatical settlement act" and "stranger-originated life insurance practice." The definitions and their effect are discussed above.

Technical Revisions

Section 4 amends s. 626.99175, F.S., to clarify the registration requirement for life expectancy providers.

Section 6 amends s. 626.9924(7), F.S., which requires viatical settlement providers to provide notice to the insurer of the policy, during the contestability period, that the policy has or will become a viaticated policy. The bill provides proper cross references and eliminates a cross-reference to a statute deleted by the bill.

Section 7 amends s. 626.99245(2), F.S., to correct a cross-reference.

Effective Date

The act takes effect July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill increases the maximum administrative fine for each nonwillful violation of s. 626.9914, F.S., from $2,500 to $10,000 and increases the maximum administrative fine for each willful violation from $10,000 to $25,000. The bill also increases the deposit requirement for viatical settlement provider licensees from $100,000 to $250,000.

C. Government Sector Impact:

The bill increases the maximum fines for violations in s. 626.9914, F.S., which will increase the fines collected by the OIR unless the number of fines levied under the statute decline substantially.

The bill requires additional forms and advertising materials to be submitted to the OIR for review prior to their use. The OIR states that it cannot anticipate the volume of advertising materials it will receive, nor the staff time that will be required to review them.

The Department of Financial Services opined that because its investigations in the viatical settlement industry primarily result from STOLI transactions, prohibiting STOLI will significantly reduce its viatical-related investigative caseload.[24]

The Office of Financial Regulation (OFR) reviewed the bill and determined that it does not have an effect on the OFR.[25]

VI. Technical Deficiencies:

Line 591 incorrectly references s. 626.9987, F.S., a statute that does not exist and is not created by this bill. The appropriate reference is s. 626.99287, F.S.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 626.9911, 626.9913, 626.9914, 626.99175, 626.9924, 626.99245, 626.99275, 626.99278, and 626.99287.

This bill creates the following sections of the Florida Statutes: 626.99185, 626.99273, 626.99276, and 626.99289.

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 January 26, 2016
The CS increases the deposit requirement for viatical settlement provider licensees from $100,000 to $250,000. The CS also provides the OIR rulemaking authority to implement 626.9913, F.S., and 626.99273, F.S. The CS also makes technical and clarifying changes.

B. Amendments:

None.

[24] Department of Financial Services, *Agency Bill Analysis of SB 650*, pgs. 3-4 (Jan. 6, 2016)(on file with the Senate Committee on Banking and Insurance).
[25] Email from Meredith Hinshelwood, Deputy Director of Governmental Relations, Florida Office of Financial Regulation, to Jamie Mongiovi (Nov. 2, 2015)(on file with the Senate Committee on Banking and Insurance).

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LEGISLATIVE ACTION

Senate	.	House
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The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 626.9911, Florida Statutes, is amended to read:

626.9911 Definitions.—As used in this act, the term:

(1) "Business of viatical settlements" means an activity involved in the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, monitoring, tracking,

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underwriting, selling, transferring, assigning, pledging, or hypothecating of, or acquiring in other manner, an interest in a life insurance policy by means of a viatical settlement contract.

(2) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, or purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but whose principal activity related to the transaction is providing funds or credit enhancement to effect the viatical settlement or the purchase of one or more viaticated policies and who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. The term does not include a nonaccredited investor or other natural person. A financing entity may not enter into a viatical settlement contract.

(3) "Fraudulent viatical settlement act" means an act or omission committed by a person who, knowingly or with the intent to defraud for the purpose of depriving another of property or for pecuniary gain, commits or allows an employee or agent to commit an act specified in this subsection.

(a) Presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by another person false or concealed material information as part of, in support of, or concerning a fact material to:

1. An application for the issuance of a viatical settlement contract or an insurance policy;

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2. The underwriting of a viatical settlement contract or an insurance policy;

3. A claim for payment or benefit pursuant to a viatical settlement contract or an insurance policy;

4. Premiums paid on an insurance policy;

5. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or an insurance policy;

6. The reinstatement or conversion of an insurance policy;

7. The solicitation, offer, effectuation, or sale of a viatical settlement contract or an insurance policy;

8. The issuance of written evidence of a viatical settlement contract or an insurance policy; or

9. A financing transaction.

(b) Employing a plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies.

(c) Engaging in a stranger-originated life insurance practice.

(d) Failing to disclose upon request by an insurer that the prospective insured has undergone a life expectancy evaluation by a person other than the insurer or its authorized representatives in connection with the issuance of the policy.

(e) Perpetuating a fraud or preventing the detection of a fraud by:

1. Removing, concealing, altering, destroying, or sequestering from the office the assets or records of a licensee or other person engaged in the business of viatical settlements;

2. Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person;

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3. Transacting in the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority to transact such business; or

4. Filing with the office or the equivalent chief insurance regulatory official of another jurisdiction a document that contains false information or conceals information about a material fact from the office or other regulatory official.

(f) Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or other person engaged in the business of viatical settlements or insurance.

(g) Recklessly entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained based on information that was falsified or concealed for the purpose of defrauding the policy's issuer, viatical settlement provider, or viator. As used in this paragraph, the term "recklessly" means acting or failing to act in conscious disregard for the relevant facts or risks, and which disregard involves a gross deviation from acceptable standards of conduct.

(h) Facilitating the viator's change of residency state to avoid the provisions of this act.

(i) Facilitating or causing the creation of a trust with a non-Florida situs or other nonresident entity for the purpose of owning a life insurance policy covering a Florida resident to avoid the provisions of this act.

(j) Facilitating or causing the transfer of the ownership of an insurance policy covering a Florida resident to a trust


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with a non-Florida situs or other nonresident entity to avoid the provisions of this act.

(k) Applying for or obtaining a loan that is secured directly or indirectly by an interest in a life insurance policy.

(l) Violating s. 626.99273(1) or (2).

(m) Attempting to commit, assisting, aiding, or abetting in the commission of or conspiring to commit an act or omission specified in this subsection.

(4) ~~(2)~~ "Independent third-party trustee or escrow agent" means an attorney, certified public accountant, financial institution, or other person providing escrow services under the authority of a regulatory body. The term does not include any person associated, affiliated, or under common control with a viatical settlement provider or viatical settlement broker.

(5) ~~(3)~~ "Life expectancy" means an opinion or evaluation as to how long a particular person is to live, or relating to such person's expected demise.

(6) ~~(4)~~ "Life expectancy provider" means a person who determines, or holds himself or herself out as determining, life expectancies or mortality ratings used to determine life expectancies under any of the following circumstances:

(a) On behalf of a viatical settlement provider, viatical settlement broker, life agent, or person engaged in the business of viatical settlements.~~;~~

(b) In connection with a viatical settlement investment, pursuant to s. 517.021(24).~~; or~~

(c) On residents of this state in connection with a viatical settlement contract or viatical settlement investment.


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(7) ~~(5)~~ "Person" has the meaning specified in s. 1.01.

(8) ~~(6)~~ "Related form" means any form, created by or on behalf of a licensee, which a viator or insured is required to sign or initial. The forms include, but are not limited to, a power of attorney, a release of medical information form, a suitability questionnaire, a disclosure document, or any addendum, schedule, or amendment to a viatical settlement contract considered necessary by a provider to effectuate a viatical settlement transaction.

(9) ~~(7)~~ "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement provider or financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust must have a written agreement with a licensed viatical settlement provider or financing entity under which the licensed viatical settlement provider or financing entity is responsible for insuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to viatical settlement transactions available to the office as if those records and files were maintained directly by the licensed viatical settlement provider. This term does not include an independent third-party trustee or escrow agent or a trust that does not enter into agreements with a viator. A related provider trust is ~~shall be~~ subject to all provisions of this act that apply to the viatical settlement provider who established the related provider trust, except s. 626.9912, which does ~~shall~~ not apply ~~be applicable~~. A viatical settlement provider may establish up to ~~no more than~~ one related provider

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trust, and the sole trustee of such related provider trust shall be the viatical settlement provider licensed under s. 626.9912. The name of the licensed viatical settlement provider shall be included within the name of the related provider trust.

(10) ~~(8)~~ "Special purpose entity" means an entity established by a licensed viatical settlement provider or by a financing entity, which may be a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets to a viatical settlement provider or financing entity. A special purpose entity may not obtain capital from any natural person or entity with less than $50 million in assets and may not enter into a viatical settlement contract.

(11) "Stranger-originated life insurance practice" means an act, practice, arrangement, or agreement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. Stranger-originated life insurance practices include, but are not limited to:

(a) The purchase of a life insurance policy with resources or guarantees from or through a person who, at the time of such policy's inception, could not lawfully initiate the policy and the execution of a verbal or written arrangement or agreement to directly or indirectly transfer the ownership of such policy or policy benefits to a third party.

(b) The creation of a trust or other entity that has the appearance of an insurable interest to initiate policies for investors, which violates insurable interest laws and the

prohibition against wagering on life.

(12) ~~(9)~~ "Viatical settlement broker" means a person who, on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator resident in this state and one or more viatical settlement providers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, licensed Certified Public Accountant, or investment adviser lawfully registered under chapter 517, who is retained to represent the viator and whose compensation is paid directly by or at the direction and on behalf of the viator.

(13) ~~(10)~~ "Viatical settlement contract" means a written agreement entered into between a viatical settlement provider, or its related provider trust, and a viator. The viatical settlement contract includes an agreement to transfer ownership or change the beneficiary designation of a life insurance policy at a later date, regardless of the date that compensation is paid to the viator. The agreement must establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or a portion of the insurance policy or certificate of insurance to the viatical settlement provider. The term also includes the

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transfer for compensation or value of an ownership or a beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or used for the principal purpose of acquiring one or more life insurance contracts that insure the life of a person residing in this state, and ~~A viatical settlement contract also includes~~ a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy. The term does not include~~, other than~~ a policy loan by a life insurance company pursuant to the terms of the life insurance contract or accelerated death provisions contained in a life insurance policy, whether issued with the original policy or as a rider, ~~or~~ a loan secured by the cash surrender value of a policy as determined by the policy issuer and the life insurance policy terms, or a loan or advance from the issuer of the policy to the policyowner.

(14)~~(11)~~ "Viatical settlement investment" has the same meaning as specified in s. 517.021.

(15)~~(12)~~ "Viatical settlement provider" means a person who, in this state, from this state, or with a resident of this state, effectuates a viatical settlement contract. The term does not include:

(a) A ~~Any~~ bank, savings bank, savings and loan association, or credit union~~, or other licensed lending institution~~ that takes an assignment of a life insurance policy as collateral for a loan.

(b) A life and health insurer that has lawfully issued a life insurance policy that provides accelerated benefits to terminally ill policyholders or certificateholders.

(c) A ~~Any~~ natural person who enters into no more than one viatical settlement contract with a viator in 1 calendar year, unless such natural person has previously been licensed under this act or is currently licensed under this act.

(d) A trust that meets the definition of a "related provider trust."

(e) A viator in this state.

(f) A financing entity.

(16) ~~(13)~~ "Viaticated policy" means a life insurance policy, or a certificate under a group policy, which is the subject of a viatical settlement contract.

(17) ~~(14)~~ "Viator" means the owner of a life insurance policy or a certificateholder under a group policy, which policy is not a previously viaticated policy, who enters or seeks to enter into a viatical settlement contract. This term does not include a viatical settlement provider, ~~or~~ a ~~any~~ person acquiring a policy or interest in a policy from a viatical settlement provider, or ~~nor does it include~~ an independent third-party trustee or escrow agent.

Section 2. Subsections (2) and (3) of section 626.9913, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

626.9913 Viatical settlement provider license continuance; annual report; fees; deposit.—

(2)(a) Annually, on or before March 1, the viatical settlement provider licensee shall file a statement containing information the commission requires and shall pay to the office a license fee in the amount of $500.

(b) In addition to any other requirements, the annual

statement must specify:

1. The total number of unsettled viatical settlement contracts and corresponding total amount due to viators under viatical settlement contracts that have been signed by the viator but have not been settled as of December 31 of the preceding calendar year, categorized by the number of days since the viator signed the contract for transactions regulated by this state.

2. For each of the most recent 5 years, the total number of policies purchased, total gross amount paid for policies purchased, total commissions or compensation paid for policies purchased, and total face value of policies purchased, allocated by state, territory, and jurisdiction.

3. For the most recent calendar year, the total amount of proceeds or compensation paid to policyowners, allocated by state, territory, and jurisdiction.

(c) ~~After December 31, 2007,~~ The annual statement shall include an annual audited financial statement of the viatical settlement provider prepared in accordance with generally accepted accounting principles by an independent certified public accountant covering a 12-month period ending on a day occurring within ~~falling during~~ the last 6 months of the preceding calendar year. If the audited financial statement has not been completed, however, the licensee shall include in its annual statement an unaudited financial statement for the preceding calendar year and an affidavit from an officer of the licensee stating that the audit has not been completed. In this event, the licensee shall submit the audited statement on or before June 1. The annual statement, due on or before March 1

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each year, shall also provide the office with a report of all life expectancy providers who have provided life expectancies directly or indirectly to the viatical settlement provider for use in connection with a viatical settlement contract or a viatical settlement investment. A viatical settlement provider shall include in all statements filed with the office all information requested by the office regarding a related provider trust established by the viatical settlement provider. The office may require more frequent reporting. Failure to timely file the annual statement or the audited financial statement or to timely pay the license fee is grounds for immediate suspension of the license. The commission may by rule require all or part of the statements or filings required under this section to be submitted by electronic means in a computer-readable form compatible with the electronic data format specified by the commission.

(3) To ensure the faithful performance of its obligations to its viators in the event of insolvency or the loss of its license, a viatical settlement provider licensee must deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52, having at all times a value of not less than $250,000 ~~$100,000; however, a viatical settlement provider licensed in this state prior to June 1, 2004, which has deposited and maintains continuously deposited in trust with the department securities in the amount of $25,000 and which posted and maintains continuously posted a security bond acceptable to the department in the amount of $75,000, has until June 1, 2005, to comply with the requirements of this subsection~~.

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(6) The commission may adopt rules to implement this section.

Section 3. Subsections (1) and (2) of section 626.9914, Florida Statutes, are amended to read:

626.9914 Suspension, revocation, denial, or nonrenewal of viatical settlement provider license; grounds; administrative fine.—

(1) The office shall suspend, revoke, deny, or refuse to renew the license of any viatical settlement provider if the office finds that the licensee has committed any of the following acts:

(a) Has made a misrepresentation in the application for the license.~~;~~

(b) Has engaged in fraudulent or dishonest practices, or otherwise has been shown to be untrustworthy or incompetent to act as a viatical settlement provider.~~;~~

(c) Demonstrates a pattern of unreasonable payments to viators.~~;~~

(d) Has been found guilty of, or has pleaded guilty or nolo contendere to, any felony, or a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court.~~;~~

(e) Has issued viatical settlement contracts that have not been approved pursuant to this act.~~;~~

(f) Has failed to honor contractual obligations related to the business of viatical settlement contracts.~~;~~

(g) Deals in bad faith with viators.~~;~~

(h) Has violated any provision of the insurance code or of this act.~~;~~


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(i) Employs or contracts with a ~~any~~ person who materially influences the licensee's conduct and who fails to meet the requirements of this act.~~;~~

(j) No longer meets the requirements for initial licensure.~~; or~~

(k) Obtains or utilizes life expectancies from life expectancy providers who are not registered with the office pursuant to this act.

(l) Has engaged in a fraudulent viatical settlement act.

(2) The office may, in lieu of or in addition to any suspension or revocation, assess an administrative fine not to exceed $10,000 ~~$2,500~~ for each nonwillful violation or $25,000 ~~$10,000~~ for each willful violation by a viatical settlement provider licensee. The office may also place a viatical settlement provider licensee on probation for a period not to exceed 2 years.

Section 4. Subsection (1) of section 626.99175, Florida Statutes, is amended to read:

626.99175 Life expectancy providers; registration required; denial, suspension, revocation.—

(1) ~~After July 1, 2006,~~ A person may not perform the functions of a life expectancy provider without first having registered as a life expectancy provider~~, except as provided in subsection (6)~~.

Section 5. Section 626.99185, Florida Statutes, is created to read:

626.99185 Disclosures to viator of disbursement.—

(1) Before or concurrently with a viator's execution of a viatical settlement contract, the viatical settlement provider

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shall provide to the viator, in duplicate, a disclosure statement in legible written form disclosing:

(a) The name of each viatical settlement broker who receives or will receive compensation and the amount of each broker's compensation related to that transaction. For the purpose of this section, compensation includes anything of value paid or given by or at the direction of a viatical settlement provider or person acquiring an interest in one or more life insurance policies to a viatical settlement broker in connection with the viatical settlement contract.

(b) A complete reconciliation of the gross offer or bid by the viatical settlement provider to the net amount of proceeds or value to be received by the viator related to that transaction. As used in this section, the term "gross offer" or "bid" means the total amount or value offered by the viatical settlement provider for the purchase of an interest in one or more life insurance policies, including commissions, compensation, or other proceeds or value being deducted from the gross offer or bid.

(2) The viator shall sign and date the disclosure statement before or concurrently with the viator's execution of a viatical settlement contract, with the viator retaining the duplicate copy of the disclosure statement.

(3) If a viatical settlement contract is entered into and the contract is subsequently amended or if there is a change in the viatical settlement provider's gross offer or bid amount, a change in the net amount of proceeds or value to be received by the viator, or a change in the information provided in the disclosure statement to the viator, the viatical settlement

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provider shall provide, in duplicate, an amended disclosure statement to the viator containing the information in subsection (1). The viator shall sign and date the amended disclosure statement, with the viator retaining the duplicate copy of the amended disclosure statement.

(4) Before a viatical settlement provider's execution of a viatical settlement contract or an amendment to such contract, the viatical settlement provider must obtain the signed and dated disclosure statement and any amended disclosure statement required by this section. In transactions for which a broker is not used, the viatical settlement provider must obtain the signed and dated disclosure statement from the viator.

(5) The viatical settlement provider shall maintain the documentation required by this section pursuant to s. 626.9922(2) and shall make such documentation available to the office at any time for copying and inspection upon reasonable notice by the office to the viatical settlement provider.

Section 6. Subsection (7) of section 626.9924, Florida Statutes, is amended to read:

626.9924 Viatical settlement contracts; procedures; rescission.—

(7) At any time during the contestable period, within 20 days after a viator executes documents necessary to transfer rights under an insurance policy or within 20 days of any agreement, option, promise, or any other form of understanding, express or implied, to viaticate the policy, the provider must give notice to the insurer of the policy that the policy has or will become a viaticated policy. The notice must be accompanied by the documents required by ss. 626.99276 and 626.99287 ~~s.~~

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~~626.99287(5)(a)~~ in their entirety.

Section 7. Subsection (2) of section 626.99245, Florida Statutes, is amended to read:

626.99245 Conflict of regulation of viaticals.—

(2) This section does not affect the requirement of ss. 626.9911(15) ~~(12)~~ and 626.9912(1) that a viatical settlement provider doing business from this state must obtain a viatical settlement license from the office. As used in this subsection, the term "doing business from this state" includes effectuating viatical settlement contracts from offices in this state, regardless of the state of residence of the viator.

Section 8. Section 626.99273, Florida Statutes, is created to read:

626.99273 Prohibited practices and conflicts of interest.—

(1) With respect to a viatical settlement contract or an insurance policy, a viatical settlement broker may not knowingly solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker.

(2) With respect to a viatical settlement contract or an insurance policy, a viatical settlement provider may not knowingly enter into a viatical settlement contract with a viator if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider, financing entity, or related provider trust that is involved in such viatical settlement

contract.

(3) A viatical settlement provider may not enter into a viatical settlement contract unless the viatical settlement promotional, advertising, and marketing materials, as may be prescribed by rule, have been filed with the office. Such materials may not expressly indicate, or include any reference that would cause a viator to reasonably believe, that the life insurance is free for any period of time.

(4) A life insurance agent, insurer, viatical settlement broker, or viatical settlement provider may not make a statement or representation to an applicant or policyholder in connection with the sale of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time.

(5) The commission may adopt rules to implement this section.

Section 9. Section 626.99275, Florida Statutes, is amended to read:

626.99275 Prohibited practices; penalties.—

(1) It is unlawful for a ~~any~~ person to:

(a) ~~To~~ Knowingly enter into, broker, or otherwise deal in a viatical settlement contract the subject of which is a life insurance policy, knowing that the policy was obtained by presenting materially false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator’s agent intended to defraud the policy’s issuer.

(b) ~~To~~ Knowingly or with the intent to defraud, for the

purpose of depriving another of property or for pecuniary gain, issue or use a pattern of false, misleading, or deceptive life expectancies.

(c) ~~To~~ Knowingly engage in any transaction, practice, or course of business intending thereby to avoid the notice requirements of s. 626.9924(7).

(d) ~~To~~ Knowingly or intentionally facilitate the change of state of residency of a viator to avoid the provisions of this chapter.

(e) Knowingly enter into a viatical settlement contract before the application for or issuance of a life insurance policy that is the subject of a viatical settlement contract or during the 5-year period commencing on the date of issuance of the policy or certificate, unless the viator provides a sworn affidavit and accompanying documentation in accordance with s. 626.9987.

(f) Knowingly issue, solicit, market, or otherwise promote the purchase of a life insurance policy for the purpose of or with an emphasis on selling the policy.

(g) Engage in a fraudulent viatical settlement act.

(2) A person who violates any provision of this section commits:

(a) A felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at any amount less than $20,000.

(b) A felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at $20,000 or more, but less than $100,000.

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(c) A felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at $100,000 or more.

Section 10. Section 626.99276, Florida Statutes, is created to read:

626.99276 Notification to insurer required.—

(1) A copy of the sworn affidavit and the documentation required in s. 626.99287 must be submitted to the insurer if the viatical settlement provider or other party entering into a viatical settlement contract with a viator submits a request to the insurer for verification of coverage or if the viatical settlement provider submits a request to transfer the policy or certificate to the provider. If the request is made by a viatical settlement provider, the copy shall be accompanied by a sworn affidavit from the viatical settlement provider affirming that the copy is a true and correct copy of the documentation received by the provider.

(2) An insurer may not require, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical settlement contract, that the viator, insured, viatical settlement provider, or viatical settlement broker sign any disclosures, consent form, waiver form, or other form that has not been approved by the office for use in connection with viatical settlement contracts in this state.

(3) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within 30 calendar days confirming that the change has been effectuated or specifying the reasons why the

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requested change cannot be processed. The insurer may not unreasonably delay effectuating a change of ownership or beneficiary and may not otherwise seek to interfere with any viatical settlement contract lawfully entered into in this state.

Section 11. Section 626.99278, Florida Statutes, is amended to read:

626.99278 Viatical provider anti-fraud plan.—

(1) Each ~~Every~~ licensed viatical settlement provider and registered life expectancy provider must adopt an anti-fraud plan and file it with the Division of Insurance Fraud of the department. Each anti-fraud plan shall include:

(a) ~~(1)~~ A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications.

(b) ~~(2)~~ A description of the procedures for the mandatory reporting of possible fraudulent insurance acts and prohibited practices specified ~~set forth~~ in s. 626.99275 to the Division of Insurance Fraud ~~of the department~~.

(c) ~~(3)~~ A description of the plan for anti-fraud education and training of its underwriters or other personnel.

(d) ~~(4)~~ A written description or chart outlining the organizational arrangement of the anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and for the investigation of unresolved material inconsistencies between medical records and insurance applications.

(e) ~~(5)~~ For viatical settlement providers, a description of

the procedures used to perform initial and continuing review of the accuracy of life expectancies used in connection with a viatical settlement contract or viatical settlement investment.

(2) Each licensed viatical settlement provider shall maintain in accordance with s. 626.9922:

(a) Documentation of compliance with its anti-fraud plan and procedures filed in accordance with this section.

(b) Documentation pertaining to resolved and unresolved material inconsistencies between medical records and insurance applications.

(c) Documentation of its mandatory reporting of the possible fraudulent acts and prohibited practices specified in s. 626.99275 to the Division of Insurance Fraud.

Section 12. Section 626.99287, Florida Statutes, is amended, to read:

626.99287 Contestability of viaticated policies.—Except as hereinafter provided, if a viatical settlement contract is entered into during ~~within~~ the 5-year ~~2-year~~ period commencing on ~~with~~ the date of issuance of the insurance policy or certificate to be acquired, the viatical settlement contract is void and unenforceable by either party. Notwithstanding this limitation, such a viatical settlement contract is not void and unenforceable if the viator provides a sworn affidavit and accompanying documentation that certifies to the viatical settlement provider that one or more of the following conditions were met during the 5-year period:

(1) The policy was issued upon the owner’s exercise of conversion rights arising out of a group or term policy, if the total time covered under the prior policy is at least 60 months.

The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship;

(2) The owner of the policy is a charitable organization exempt from taxation under 26 U.S.C. s. 501(c)(3);

(3) The owner of the policy is not a natural person;

(4) The viatical settlement contract was entered into before July 1, 2000;

(5) The viator certifies by producing independent evidence to the viatical settlement provider that one or more of the following conditions were ~~have been~~ met during ~~within~~ the 5-year ~~2-year~~ period:

(a)~~1.~~ The viator or insured is terminally or chronically ill ~~diagnosed with an illness or condition that is either:~~

~~a. Catastrophic or life threatening; or~~

~~b. Requires a course of treatment for a period of at least 3 years of long-term care or home health care;~~ and

~~2.~~ the condition was not known to the insured at the time the life insurance contract was entered into;~~.~~

(b) The viator's spouse dies;

(c) The viator divorces his or her spouse;

(d) The viator retires from full-time employment;

(e) The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment;

(f) The owner of the policy was the insured's employer at the time the policy or certificate was issued and the employment relationship terminated;

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(g) A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the viator, adjudicating the viator bankrupt or insolvent, or approving a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets; or

(h) The viator experiences a significant decrease in income which is unexpected by the viator and which impairs his or her reasonable ability to pay the policy premium.

(6) The viator entered into a viatical settlement contract more than 2 years after the policy's issuance date and, with respect to the policy, at all times before such date each of the following conditions were met:

(a) Policy premiums were funded exclusively with unencumbered assets, including an interest in the life insurance policy being financed but only to the extent of its net cash surrender value provided by or full recourse liability incurred by the insured;

(b) An agreement or understanding with another person was not entered into to guarantee any such liability or to purchase, or agree to purchase, the policy, including through an assumption or forgiveness of the loan; and

(c) The insured and the policy were not evaluated for settlement.

~~If the viatical settlement provider submits to the insurer a copy of the viator's or owner's certification described above, then the provider submits a request to the insurer to effect the transfer of the policy or certificate to the viatical settlement~~

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~~provider, the viatical settlement agreement shall not be void or unenforceable by operation of this section. The insurer shall timely respond to such request. Nothing in this section shall prohibit an insurer from exercising its right during the contestability period to contest the validity of any policy on grounds of fraud.~~

Section 13. Section 626.99289, Florida Statutes, is created to read:

626.99289 Void and unenforceable contracts, agreements, arrangements, and transactions.—A contract, agreement, arrangement, or transaction, including, but not limited to, a financing agreement or any other arrangement or understanding entered into, whether written or verbal, for the furtherance or aid of a stranger-originated life insurance practice is void and unenforceable.

Section 14. This act shall take effect July 1, 2016.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to viatical settlements; amending s. 626.9911, F.S.; revising definitions; defining the terms "business of viatical settlements," "fraudulent viatical settlement act," and "stranger-originated life insurance practice"; amending s. 626.9913, F.S.; requiring additional information in an annual statement filed by viatical settlement provider

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licensees; revising deposit requirements for viatical settlement provider licensees; deleting an obsolete provision regarding a deposit requirement; authorizing the Financial Services Commission to adopt rules; amending s. 626.9914, F.S.; adding an act that warrants the imposition of administrative penalties against viatical settlement provider licensees; increasing the amount of administrative fines that may be imposed by the Office of Insurance Regulation against licensees for certain violations; amending s. 626.99175, F.S.; deleting an obsolete provision; deleting an exception from registration requirements for life expectancy providers; creating s. 626.99185, F.S.; requiring viatical settlement providers to provide viators with a disclosure statement before or concurrently with a viator’s execution of a viatical settlement contract; providing requirements and procedures for such disclosure statements; amending s. 626.9924, F.S.; correcting cross-references relating to a requirement to provide specified documents with a notice that a policy has or will become a viaticated policy; amending s. 626.99245, F.S.; conforming a cross-reference; creating s. 626.99273, F.S.; prohibiting certain practices and conflicts of interest relating to viatical settlement contracts or insurance policies; requiring a viatical settlement provider to file certain promotional, advertising, and marketing materials with the office before entering into viatical settlement contracts; prohibiting

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certain references relating to the cost of life insurance policies in such materials and other specified statements and representations; authorizing the commission to adopt rules; amending s. 626.99275, F.S.; prohibiting a person from entering into a viatical settlement contract before a specified date except under specified circumstances, from issuing, soliciting, marketing, or otherwise promoting the purchase of a policy under certain circumstances, and from engaging in a fraudulent viatical settlement act; providing criminal penalties for a violation of such prohibitions; creating s. 626.99276, F.S.; requiring specified affidavits and other documentation to be provided to an insurer for requests to verify coverage and to transfer a policy or certificate to a viatical settlement provider; prohibiting insurers from requiring certain forms that have not been approved by the office to be signed as a condition of responding to such requests; requiring insurers to respond in writing during a specified period to properly completed requests to change the ownership or beneficiary of a policy; amending s. 626.99278, F.S.; providing requirements for licensed viatical settlement providers to maintain specified documentation relating to anti-fraud plans and procedures, material inconsistencies between medical records and insurance applications, and reporting of specified fraudulent acts and prohibited practices; amending s. 626.99287, F.S.; revising the period

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765 during which certain viatical settlement contracts are
766 void and unenforeceable; revising exceptions to such
767 contracts being void and unenforceable; creating s.
768 626.99289, F.S.; providing that certain contracts,
769 agreements, arrangements, and transactions relating to
770 stranger-originated life insurance practices are void
771 and unenforceable; providing an effective date.

By Senator Legg

17-00027-16 2016650__

A bill to be entitled

An act relating to viatical settlements; amending s. 626.9911, F.S.; revising definitions; defining the terms "business of viatical settlements," "fraudulent viatical settlement act," and "stranger-originated life insurance practice"; amending s. 626.9913, F.S.; requiring additional information in an annual statement filed by viatical settlement provider licensees; deleting an obsolete provision regarding a deposit requirement; amending s. 626.9914, F.S.; adding an act that warrants the imposition of administrative penalties against viatical settlement provider licensees; increasing the amount of administrative fines that may be imposed by the Office of Insurance Regulation against licensees for certain violations; amending s. 626.99175, F.S.; deleting an obsolete provision; deleting an exception from registration requirements for life expectancy providers; creating s. 626.99185, F.S.; requiring viatical settlement providers to provide viators with a disclosure statement before or concurrently with a viator's execution of a viatical settlement contract; providing requirements and procedures for such disclosure statements; amending s. 626.9924, F.S.; deleting a requirement to provide specified documents with a notice that a policy has or will become a viaticated policy; amending s. 626.99245, F.S.; conforming a cross-reference; creating s. 626.99273, F.S.; prohibiting certain practices and conflicts of

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interest relating to viatical settlement contracts or insurance policies; requiring a viatical settlement provider to file certain promotional, advertising, and marketing materials with the office before entering into viatical settlement contracts; prohibiting certain references relating to the cost of life insurance policies in such materials and other specified statements and representations; amending s. 626.99275, F.S.; prohibiting a person from entering into a viatical settlement contract before a specified date except under specified circumstances, from issuing, soliciting, marketing, or otherwise promoting the purchase of a policy under certain circumstances, and from engaging in a fraudulent viatical settlement act; providing criminal penalties for a violation of such prohibitions; creating s. 626.99276, F.S.; requiring specified affidavits and other documentation to be provided to an insurer for requests to verify coverage and to transfer a policy or certificate to a viatical settlement provider; prohibiting insurers from requiring certain forms that have not been approved by the office to be signed as a condition of responding to such requests; requiring insurers to respond in writing within a specified period to properly completed requests to change the ownership or beneficiary of a policy; amending s. 626.99278, F.S.; providing requirements for licensed viatical settlement providers to maintain specified documentation relating to anti-fraud plans and

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

procedures, material inconsistencies between medical records and insurance applications, and reporting of specified fraudulent acts and prohibited practices; repealing s. 626.99287, F.S., relating to the contestability of viaticated policies; creating s. 626.99289, F.S.; providing that certain contracts, agreements, arrangements, and transactions relating to stranger-originated life insurance practices are void and unenforceable; providing an effective date.

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

Section 1. Section 626.9911, Florida Statutes, is amended to read:

626.9911 Definitions.—As used in this act, the term:

(1) "Business of viatical settlements" means an activity involved in the offering, soliciting, negotiating, procuring, effectuating, purchasing, investing, monitoring, tracking, underwriting, selling, transferring, assigning, pledging, or hypothecating of, or acquiring in other manner, an interest in a life insurance policy by means of a viatical settlement contract.

(2) "Financing entity" means an underwriter, placement agent, lender, purchaser of securities, or purchaser of a policy or certificate from a viatical settlement provider, credit enhancer, or any entity that has direct ownership in a policy or certificate that is the subject of a viatical settlement contract, but whose principal activity related to the transaction is providing funds or credit enhancement to effect

the viatical settlement or the purchase of one or more viaticated policies and who has an agreement in writing with one or more licensed viatical settlement providers to finance the acquisition of viatical settlement contracts. The term does not include a nonaccredited investor or other natural person. A financing entity may not enter into a viatical settlement contract.

(3) "Fraudulent viatical settlement act" means an act or omission committed by a person who, knowingly or with the intent to defraud for the purpose of depriving another of property or for pecuniary gain, commits or allows an employee or agent to commit an act specified in this subsection.

(a) Presenting, causing to be presented, or preparing with the knowledge or belief that it will be presented to or by another person false or concealed material information as part of, in support of, or concerning a fact material to:

1. An application for the issuance of a viatical settlement contract or an insurance policy;

2. The underwriting of a viatical settlement contract or an insurance policy;

3. A claim for payment or benefit pursuant to a viatical settlement contract or an insurance policy;

4. Premiums paid on an insurance policy;

5. Payments and changes in ownership or beneficiary made in accordance with the terms of a viatical settlement contract or an insurance policy;

6. The reinstatement or conversion of an insurance policy;

7. The solicitation, offer, effectuation, or sale of a viatical settlement contract or an insurance policy;

8. The issuance of written evidence of a viatical settlement contract or an insurance policy; or

9. A financing transaction.

(b) Employing a plan, financial structure, device, scheme, or artifice to defraud related to viaticated policies.

(c) Engaging in a stranger-originated life insurance practice.

(d) Failing to disclose upon request by an insurer that the prospective insured has undergone a life expectancy evaluation by a person other than the insurer or its authorized representatives in connection with the issuance of the policy.

(e) Perpetuating a fraud or preventing the detection of a fraud by:

1. Removing, concealing, altering, destroying, or sequestering from the office the assets or records of a licensee or other person engaged in the business of viatical settlements;

2. Misrepresenting or concealing the financial condition of a licensee, financing entity, insurer, or other person;

3. Transacting in the business of viatical settlements in violation of laws requiring a license, certificate of authority, or other legal authority to transact such business; or

4. Filing with the office or the equivalent chief insurance regulatory official of another jurisdiction a document that contains false information or conceals information about a material fact from the office or other regulatory official.

(f) Embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a viatical settlement provider, insurer, insured, viator, insurance policyowner, or other person engaged in the business

of viatical settlements or insurance.

(g) Recklessly entering into, negotiating, brokering, or otherwise dealing in a viatical settlement contract, the subject of which is a life insurance policy that was obtained based on information that was falsified or concealed for the purpose of defrauding the policy's issuer, viatical settlement provider, or viator. As used in this paragraph, the term "recklessly" means acting or failing to act in conscious disregard for the relevant facts or risks, and which disregard involves a gross deviation from acceptable standards of conduct.

(h) Facilitating the viator's change of residency state to avoid the provisions of this act.

(i) Facilitating or causing the creation of a trust with a non-Florida situs or other nonresident entity for the purpose of owning a life insurance policy covering a Florida resident to avoid the provisions of this act;

(j) Facilitating or causing the transfer of the ownership of an insurance policy covering a Florida resident to a trust with a non-Florida situs or other nonresident entity to avoid the provisions of this act.

(k) Applying for or obtaining a loan that is secured directly or indirectly by an interest in a life insurance policy.

(l) Violating s. 626.99273(1) or (2).

(m) Attempting to commit, assisting, aiding, or abetting in the commission of or conspiring to commit an act or omission specified in this subsection.

(4)~~(2)~~ "Independent third-party trustee or escrow agent" means an attorney, certified public accountant, financial

institution, or other person providing escrow services under the authority of a regulatory body. The term does not include any person associated, affiliated, or under common control with a viatical settlement provider or viatical settlement broker.

(5) ~~(3)~~ "Life expectancy" means an opinion or evaluation as to how long a particular person is to live, or relating to such person's expected demise.

(6) ~~(4)~~ "Life expectancy provider" means a person who determines, or holds himself or herself out as determining, life expectancies or mortality ratings used to determine life expectancies under any of the following circumstances:

(a) On behalf of a viatical settlement provider, viatical settlement broker, life agent, or person engaged in the business of viatical settlements.~~;~~

(b) In connection with a viatical settlement investment, pursuant to s. 517.021(24).~~; or~~

(c) On residents of this state in connection with a viatical settlement contract or viatical settlement investment.

(7) ~~(5)~~ "Person" has the meaning specified in s. 1.01.

(8) ~~(6)~~ "Related form" means any form, created by or on behalf of a licensee, which a viator or insured is required to sign or initial. The forms include, but are not limited to, a power of attorney, a release of medical information form, a suitability questionnaire, a disclosure document, or any addendum, schedule, or amendment to a viatical settlement contract considered necessary by a provider to effectuate a viatical settlement transaction.

(9) ~~(7)~~ "Related provider trust" means a titling trust or other trust established by a licensed viatical settlement

provider or financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. The trust must have a written agreement with a licensed viatical settlement provider or financing entity under which the licensed viatical settlement provider or financing entity is responsible for insuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to viatical settlement transactions available to the office as if those records and files were maintained directly by the licensed viatical settlement provider. This term does not include an independent third-party trustee or escrow agent or a trust that does not enter into agreements with a viator. A related provider trust is ~~shall be~~ subject to all provisions of this act that apply to the viatical settlement provider who established the related provider trust, except s. 626.9912, which does ~~shall~~ not apply ~~be applicable~~. A viatical settlement provider may establish up to ~~no more than~~ one related provider trust, and the sole trustee of such related provider trust shall be the viatical settlement provider licensed under s. 626.9912. The name of the licensed viatical settlement provider shall be included within the name of the related provider trust.

(10) ~~(8)~~ "Special purpose entity" means an entity established by a licensed viatical settlement provider or by a financing entity, which may be a corporation, partnership, trust, limited liability company, or other similar entity formed solely to provide, either directly or indirectly, access to institutional capital markets to a viatical settlement provider or financing entity. A special purpose entity may not obtain

capital from any natural person or entity with less than $50 million in assets and may not enter into a viatical settlement contract.

(11) "Stranger-originated life insurance practice" means an act, practice, arrangement, or agreement to initiate a life insurance policy for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest in the insured. Stranger-originated life insurance practices include, but are not limited to:

(a) The purchase of a life insurance policy with resources or guarantees from or through a person who, at the time of such policy's inception, could not lawfully initiate the policy and the execution of a verbal or written arrangement or agreement to directly or indirectly transfer the ownership of such policy or policy benefits to a third party.

(b) The creation of a trust that has the appearance of an insurable interest to initiate policies for investors, which violates insurable interest laws and the prohibition against wagering on life.

(12) ~~(9)~~ "Viatical settlement broker" means a person who, on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator resident in this state and one or more viatical settlement providers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, licensed

Certified Public Accountant, or investment adviser lawfully registered under chapter 517, who is retained to represent the viator and whose compensation is paid directly by or at the direction and on behalf of the viator.

(13) ~~(10)~~ "Viatical settlement contract" means a written agreement entered into between a viatical settlement provider, or its related provider trust, and a viator. The viatical settlement contract includes an agreement to transfer ownership or change the beneficiary designation of a life insurance policy at a later date, regardless of the date that compensation is paid to the viator. The agreement must establish the terms under which the viatical settlement provider will pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise, or bequest of the death benefit or ownership of all or a portion of the insurance policy or certificate of insurance to the viatical settlement provider. The term also includes the transfer for compensation or value of an ownership or a beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or used for the principal purpose of acquiring one or more life insurance contracts that insure the life of a person residing in this state, and ~~A viatical settlement contract also includes~~ a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy. The term does not include~~, other than~~ a policy loan by a life insurance company pursuant to the terms of the life insurance contract or accelerated death provisions contained in a life

insurance policy, whether issued with the original policy or as a rider, ~~or~~ a loan secured by the cash surrender value of a policy as determined by the policy issuer and the life insurance policy terms, or a loan or advance from the issuer of the policy to the policyowner.

(14)~~(11)~~ "Viatical settlement investment" has the same meaning as specified in s. 517.021.

(15)~~(12)~~ "Viatical settlement provider" means a person who, in this state, from this state, or with a resident of this state, effectuates a viatical settlement contract. The term does not include:

(a) A ~~Any~~ bank, savings bank, savings and loan association, or credit union~~, or other licensed lending institution~~ that takes an assignment of a life insurance policy as collateral for a loan.

(b) A life and health insurer that has lawfully issued a life insurance policy that provides accelerated benefits to terminally ill policyholders or certificateholders.

(c) A ~~Any~~ natural person who enters into no more than one viatical settlement contract with a viator in 1 calendar year, unless such natural person has previously been licensed under this act or is currently licensed under this act.

(d) A trust that meets the definition of a "related provider trust."

(e) A viator in this state.

(f) A financing entity.

(16)~~(13)~~ "Viaticated policy" means a life insurance policy, or a certificate under a group policy, which is the subject of a viatical settlement contract.

(17)~~(14)~~ "Viator" means the owner of a life insurance policy or a certificateholder under a group policy, which policy is not a previously viaticated policy, who enters or seeks to enter into a viatical settlement contract. This term does not include a viatical settlement provider, ~~or~~ a ~~any~~ person acquiring a policy or interest in a policy from a viatical settlement provider, or ~~nor does it include~~ an independent third-party trustee or escrow agent.

Section 2. Subsections (2) and (3) of section 626.9913, Florida Statutes, are amended to read:

626.9913 Viatical settlement provider license continuance; annual report; fees; deposit.—

(2)(a) Annually, on or before March 1, the viatical settlement provider licensee shall file a statement containing information the commission requires and shall pay to the office a license fee in the amount of $500.

(b) In addition to any other requirements, the annual statement must specify:

1. The total number of unsettled viatical settlement contracts and corresponding total amount due to viators under viatical settlement contracts that have been signed by the viator but have not been settled as of December 31 of the preceding calendar year, categorized by the number of days since the viator signed the contract for transactions regulated by this state.

2. For the most recent 5 years, the total number of policies purchased, total gross amount paid for policies purchased, total commissions or compensation paid for policies purchased, and total face value of policies purchased, allocated

by state, territory, and jurisdiction.

3. The total amount of proceeds or compensation paid to policyowners, allocated by state, territory, and jurisdiction.

(c) ~~After December 31, 2007,~~ The annual statement shall include an annual audited financial statement of the viatical settlement provider prepared in accordance with generally accepted accounting principles by an independent certified public accountant covering a 12-month period ending on a day occurring within ~~falling during~~ the last 6 months of the preceding calendar year. If the audited financial statement has not been completed, however, the licensee shall include in its annual statement an unaudited financial statement for the preceding calendar year and an affidavit from an officer of the licensee stating that the audit has not been completed. In this event, the licensee shall submit the audited statement on or before June 1. The annual statement, due on or before March 1 each year, shall also provide the office with a report of all life expectancy providers who have provided life expectancies directly or indirectly to the viatical settlement provider for use in connection with a viatical settlement contract or a viatical settlement investment. A viatical settlement provider shall include in all statements filed with the office all information requested by the office regarding a related provider trust established by the viatical settlement provider. The office may require more frequent reporting. Failure to timely file the annual statement or the audited financial statement or to timely pay the license fee is grounds for immediate suspension of the license. The commission may by rule require all or part of the statements or filings required under this

section to be submitted by electronic means in a computer-readable form compatible with the electronic data format specified by the commission.

(3) To ensure the faithful performance of its obligations to its viators in the event of insolvency or the loss of its license, a viatical settlement provider licensee must deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52, having at all times a value of not less than $100,000~~; however, a viatical settlement provider licensed in this state prior to June 1, 2004, which has deposited and maintains continuously deposited in trust with the department securities in the amount of $25,000 and which posted and maintains continuously posted a security bond acceptable to the department in the amount of $75,000, has until June 1, 2005, to comply with the requirements of this subsection~~.

Section 3. Subsections (1) and (2) of section 626.9914, Florida Statutes, are amended to read:

626.9914 Suspension, revocation, denial, or nonrenewal of viatical settlement provider license; grounds; administrative fine.—

(1) The office shall suspend, revoke, deny, or refuse to renew the license of any viatical settlement provider if the office finds that the licensee has committed any of the following acts:

(a) Has made a misrepresentation in the application for the license.~~;~~

(b) Has engaged in fraudulent or dishonest practices, or otherwise has been shown to be untrustworthy or incompetent to act as a viatical settlement provider.~~;~~

(c) Demonstrates a pattern of unreasonable payments to viators.~~;~~

(d) Has been found guilty of, or has pleaded guilty or nolo contendere to, any felony, or a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court.~~;~~

(e) Has issued viatical settlement contracts that have not been approved pursuant to this act.~~;~~

(f) Has failed to honor contractual obligations related to the business of viatical settlement contracts.~~;~~

(g) Deals in bad faith with viators.~~;~~

(h) Has violated any provision of the insurance code or of this act.~~;~~

(i) Employs a ~~any~~ person who materially influences the licensee's conduct and who fails to meet the requirements of this act.~~;~~

(j) No longer meets the requirements for initial licensure.~~; or~~

(k) Obtains or utilizes life expectancies from life expectancy providers who are not registered with the office pursuant to this act.

(l) Has engaged in a fraudulent viatical settlement act.

(2) The office may, in lieu of or in addition to any suspension or revocation, assess an administrative fine not to exceed $10,000 ~~$2,500~~ for each nonwillful violation or $25,000 ~~$10,000~~ for each willful violation by a viatical settlement provider licensee. The office may also place a viatical settlement provider licensee on probation for a period not to exceed 2 years.

Section 4. Subsection (1) of section 626.99175, Florida Statutes, is amended to read:

626.99175 Life expectancy providers; registration required; denial, suspension, revocation.—

(1) ~~After July 1, 2006,~~ A person may not perform the functions of a life expectancy provider without first having registered as a life expectancy provider~~, except as provided in subsection (6)~~.

Section 5. Section 626.99185, Florida Statutes, is created to read:

626.99185 Disclosures to viator of disbursement.—

(1) Before or concurrently with a viator's execution of a viatical settlement contract, the viatical settlement provider shall provide to the viator, in duplicate, a disclosure statement in legible written form disclosing:

(a) The name of each viatical settlement broker who receives or will receive compensation and the amount of each broker's compensation related to that transaction. For the purpose of this section, compensation includes anything of value paid or given by or at the direction of a viatical settlement provider or person acquiring an interest in one or more life insurance policies to a viatical settlement broker in connection with the viatical settlement contract.

(b) A complete reconciliation of the gross offer or bid by the viatical settlement provider to the net amount of proceeds or value to be received by the viator related to that transaction. As used in this section, the term "gross offer" or "bid" means the total amount or value offered by the viatical settlement provider for the purchase of an interest in one or

more life insurance policies, including commissions, compensation, or other proceeds or value being deducted from the gross offer or bid.

(2) The viator shall sign and date the disclosure statement before or concurrently with the viator's execution of a viatical settlement contract, with the viator retaining the duplicate copy of the disclosure statement.

(3) If a viatical settlement contract is entered into and the contract is subsequently amended or if there is a change in the viatical settlement provider's gross offer or bid amount, a change in the net amount of proceeds or value to be received by the viator, or a change in the information provided in the disclosure statement to the viator, the viatical settlement provider shall provide, in duplicate, an amended disclosure statement to the viator containing the information in subsection (1). The viator shall sign and date the amended disclosure statement, with the viator retaining the duplicate copy of the amended disclosure statement.

(4) Before a viatical settlement provider's execution of a viatical settlement contract or an amendment to such contract, the viatical settlement provider must obtain the signed and dated disclosure statement and any amended disclosure statement required by this section. In transactions for which a broker is not used, the viatical settlement provider must obtain the signed and dated disclosure statement from the viator.

(5) The viatical settlement provider shall maintain the documentation required by this section pursuant to s. 626.9922(2) and shall make such documentation available to the office at any time for copying and inspection upon reasonable

notice by the office to the viatical settlement provider.

Section 6. Subsection (7) of section 626.9924, Florida Statutes, is amended to read:

626.9924 Viatical settlement contracts; procedures; rescission.—

(7) At any time during the contestable period, within 20 days after a viator executes documents necessary to transfer rights under an insurance policy or within 20 days of any agreement, option, promise, or any other form of understanding, express or implied, to viaticate the policy, the provider must give notice to the insurer of the policy that the policy has or will become a viaticated policy. ~~The notice must be accompanied by the documents required by s. 626.99287(5)(a) in their entirety.~~

Section 7. Subsection (2) of section 626.99245, Florida Statutes, is amended to read:

626.99245 Conflict of regulation of viaticals.—

(2) This section does not affect the requirement of ss. 626.9911(15)~~(12)~~ and 626.9912(1) that a viatical settlement provider doing business from this state must obtain a viatical settlement license from the office. As used in this subsection, the term "doing business from this state" includes effectuating viatical settlement contracts from offices in this state, regardless of the state of residence of the viator.

Section 8. Section 626.99273, Florida Statutes, is created to read:

626.99273 Prohibited practices and conflicts of interest.—

(1) With respect to a viatical settlement contract or an insurance policy, a viatical settlement broker may not knowingly

solicit an offer from, effectuate a viatical settlement with, or make a sale to any viatical settlement provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with such viatical settlement broker.

(2) With respect to a viatical settlement contract or an insurance policy, a viatical settlement provider may not knowingly enter into a viatical settlement contract with a viator if, in connection with such viatical settlement contract, anything of value will be paid to a viatical settlement broker that is controlling, controlled by, or under common control with such viatical settlement provider, financing entity, or related provider trust that is involved in such viatical settlement contract.

(3) A viatical settlement provider may not enter into a viatical settlement contract unless the viatical settlement promotional, advertising, and marketing materials, as may be prescribed by rule, have been filed with the office. Such materials may not expressly indicate, or include any reference that would cause a viator to reasonably believe, that the life insurance is free for any period of time.

(4) A life insurance producer, insurer, viatical settlement broker, or viatical settlement provider may not make a statement or representation to an applicant or policyholder in connection with the sale of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time.

Section 9. Section 626.99275, Florida Statutes, is amended to read:

626.99275 Prohibited practices; penalties.—

(1) It is unlawful for a ~~any~~ person to:

(a) ~~To~~ Knowingly enter into, broker, or otherwise deal in a viatical settlement contract the subject of which is a life insurance policy, knowing that the policy was obtained by presenting materially false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the viator or the viator's agent intended to defraud the policy's issuer.

(b) ~~To~~ Knowingly or with the intent to defraud, for the purpose of depriving another of property or for pecuniary gain, issue or use a pattern of false, misleading, or deceptive life expectancies.

(c) ~~To~~ Knowingly engage in any transaction, practice, or course of business intending thereby to avoid the notice requirements of s. 626.9924(7).

(d) ~~To~~ Knowingly or intentionally facilitate the change of state of residency of a viator to avoid the provisions of this chapter.

(e) Knowingly enter into a viatical settlement contract before the application for or issuance of a life insurance policy that is the subject of a viatical settlement contract or within a 5-year period commencing with the date of issuance of the policy or certificate, unless the viator provides a sworn affidavit and accompanying documentation that certifies to the viatical settlement provider that one or more of the following conditions have been met within the 5-year period:

1. The policy or certificate was issued upon the viator's

exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 60 months. The time covered under a group policy shall be calculated without regard to any change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.

2. The viator submits independent evidence to the viatical settlement provider that one or more of the following conditions have been met within the 5-year period:

a. The viator or insured is terminally or chronically ill;

b. The viator's spouse dies;

c. The viator divorces his or her spouse;

d. The viator retires from full-time employment;

e. The viator becomes physically or mentally disabled and a physician determines that the disability prevents the viator from maintaining full-time employment; or

f. A final order, judgment, or decree is entered by a court of competent jurisdiction, upon the application by a viator's creditor, which adjudicates the viator bankrupt or insolvent or approves a petition seeking reorganization of the viator or appointing a receiver, trustee, or liquidator to all or a substantial part of the viator's assets.

3. The viator enters into a viatical settlement contract more than 2 years after a policy's issuance date and, with respect to the policy, at all times before such date each of the following conditions is met:

a. Policy premiums have been funded exclusively with unencumbered assets, including an interest in the life insurance

policy being financed only to the extent of its net cash surrender value provided by, or full recourse liability incurred by, the insured;

b. An agreement or understanding with another person has not been entered to guarantee any such liability or to purchase, or be ready to purchase, the policy, including through an assumption or forgiveness of the loan; and

c. The insured and the policy have not been evaluated for settlement.

(f) Knowingly issue, solicit, market, or otherwise promote the purchase of a life insurance policy for the purpose of or with an emphasis on selling the policy.

(g) Engage in a fraudulent viatical settlement act.

(2) A person who violates any provision of this section commits:

(a) A felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at any amount less than $20,000.

(b) A felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at $20,000 or more, but less than $100,000.

(c) A felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, if the insurance policy involved is valued at $100,000 or more.

Section 10. Section 626.99276, Florida Statutes, is created to read:

626.99276 Notification to insurer required.—

(1) A copy of the sworn affidavit and the documentation required in s. 626.99275(1)(e) must be submitted to the insurer if the viatical settlement provider or other party entering into a viatical settlement contract with a viator submits a request to the insurer for verification of coverage or if the viatical settlement provider submits a request to transfer the policy or certificate to the provider. If the request is made by a viatical settlement provider, the copy shall be accompanied by a sworn affidavit from the viatical settlement provider affirming that the copy is a true and correct copy of the documentation received by the provider.

(2) An insurer may not require, as a condition of responding to a request for verification of coverage or effecting the transfer of a policy pursuant to a viatical settlement contract, that the viator, insured, viatical settlement provider, or viatical settlement broker sign any disclosures, consent form, waiver form, or other form that has not been approved by the office for use in connection with viatical settlement contracts in this state.

(3) Upon receipt of a properly completed request for change of ownership or beneficiary of a policy, the insurer shall respond in writing within 30 calendar days confirming that the change has been effectuated or specifying the reasons why the requested change cannot be processed. The insurer may not unreasonably delay effectuating a change of ownership or beneficiary and may not otherwise seek to interfere with any viatical settlement contract lawfully entered into in this state.

Section 11. Section 626.99278, Florida Statutes, is amended

to read:

626.99278 Viatical provider anti-fraud plan.—

(1) Each ~~Every~~ licensed viatical settlement provider and registered life expectancy provider must adopt an anti-fraud plan and file it with the Division of Insurance Fraud of the department. Each anti-fraud plan shall include:

(a) ~~(1)~~ A description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications.

(b) ~~(2)~~ A description of the procedures for the mandatory reporting of possible fraudulent insurance acts and prohibited practices specified ~~set forth~~ in s. 626.99275 to the Division of Insurance Fraud ~~of the department~~.

(c) ~~(3)~~ A description of the plan for anti-fraud education and training of its underwriters or other personnel.

(d) ~~(4)~~ A written description or chart outlining the organizational arrangement of the anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and for the investigation of unresolved material inconsistencies between medical records and insurance applications.

(e) ~~(5)~~ For viatical settlement providers, a description of the procedures used to perform initial and continuing review of the accuracy of life expectancies used in connection with a viatical settlement contract or viatical settlement investment.

(2) Each licensed viatical settlement provider shall maintain in accordance with s. 626.9922:

(a) Documentation of compliance with its anti-fraud plan

and procedures filed in accordance with this section.

(b) Documentation pertaining to resolved and unresolved material inconsistencies between medical records and insurance applications.

(c) Documentation of its mandatory reporting of the possible fraudulent acts and prohibited practices specified in s. 626.99275 to the Division of Insurance Fraud.

Section 12. Section 626.99287, Florida Statutes, is repealed.

Section 13. Section 626.99289, Florida Statutes, is created to read:

626.99289 Void and unenforceable contracts, agreements, arrangements, and transactions.—A contract, agreement, arrangement, or transaction, including, but not limited to, a financing agreement or any other arrangement or understanding entered into, whether written or verbal, for the furtherance or aid of a stranger-originated life insurance practice is void and unenforceable.

Section 14. This act shall take effect July 1, 2016.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Education Pre-K - 12, Chair
Ethics and Elections, Vice Chair
Appropriations Subcommittee on Education
Fiscal Policy
Government Oversight and Accountability
Higher Education

SENATOR JOHN LEGG
17th District

Legg.John.web@FLSenate.gov

November 18, 2015

The Honorable Lizbeth Benacquisto
Committee on Banking and Insurance, Chair
320 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

RE: SB 650 – Viatical Settlements

Dear Chair Benacquisto:

Senate Bill 650 has been referred to your committee. I respectfully request that it be placed on the Committee on Banking and Insurance Agenda, at your convenience. Your leadership and consideration are appreciated.

Sincerely,

John Legg
State Senator, District 17

cc: James Knudson, Staff Director
Sheri Green, Administrative Assistant

JL/jb

REPLY TO:
❒ 262 Crystal Grove Boulevard, Lutz, Florida 33548 (813) 909-9919
❒ 316 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5017

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

January 26, 2016
Meeting Date

650
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 650

Name Brady Cobb

Job Title Attorney

Address 642 N.E. 3rd Avenue
Street

Phone 954 527 4111

Fort Lauderdale FL 33304
City *State* *Zip*

Email bcobb@cobbeddy.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Life Insurance Settlement Association, Inc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

650
Bill Number (if applicable)

Topic Viaticals

Amendment Barcode (if applicable)

Name Richard Robleto

Job Title Deputy Commissioner

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☒ For ☐ Against ☒ Information

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

Representing Office of Insurance Regulation

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

January 26, 2016
Meeting Date

650
Bill Number (if applicable)

Topic Viatical Settlements

Amendment Barcode (if applicable)

Name Josh Aubuchon

Job Title attorney

Address 315 S. Calhoun
Street

Phone 224-7000

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

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

Representing New York Life

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date	650 Bill Number (if applicable)
Topic Viaticals	Amendment Barcode (if applicable)
Name Caitlin Murray	
Job Title Director of Government Affairs	
Address Street	Phone
City State Zip	Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing OIR

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-16
Meeting Date

SB 650
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Paul Sanford

Job Title _____

Address 106 S. Monroe St
Street

Tallahassee FL 32336
City *State* *Zip*

Phone 222-7206

Email _____

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

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

Representing FLA. FAS. Council, ACLT

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

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

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

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

S-001 (10/14/14)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

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

January 26, 2016
Meeting Date

650
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 650

Name Darwin Bayston

Job Title President and CEO-Life Insurance Settlement Association, Inc.

Address 225 E. Eola Drive
Street

Phone 407-894-3797

Orlando FL 32801
City *State* *Zip*

Email dbayston@lisa.org

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Life Insurance Settlement Association, Inc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

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/CS/SB 676
INTRODUCER:	Banking and Insurance Committee, Health Policy Committee and Senator Grimsley
SUBJECT:	Access to Health Care Services
DATE:	January 27, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Fav/CS**
2.	Johnson	Knudson	BI	**Fav/CS**
3.			AHS	
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 676 authorizes physician assistants (PAs) and advanced registered nurse practitioners (ARNPs) to prescribe controlled substances under current supervisory standards for PAs and protocols for ARNPs beginning January 1, 2017; and creates additional statutory parameters for their controlled substance prescribing. An ARNP's and PA's prescribing privileges for controlled substances listed on Schedule II are limited to a 7-day supply and do not include the prescribing of psychotropic medications for children under 18 years of age, unless prescribed by an ARNP who is a psychiatric nurse, and may be limited by the controlled substance formularies themselves imposing additional limitations on PA or ARNP prescribing privileges for specific medications. An ARNP or PA may not prescribe controlled substances in a pain management clinic. The bill requires PAs and ARNPs to complete 3 hours of continuing education biennially on the safe and effective prescribing of controlled substances.

Beginning January 1, 2017, health insurers, health maintenance organizations, Medicaid managed plans, and pharmacy benefits managers, which do not use an online prior authorization form, must use a standardized prior authorize form that the Financial Services Commission adopts by rule. If a health insurer or health maintenance organization verified the eligibility of an insured at the time of treatment, it may not retroactively deny a claim because of the insured's ineligibility.

The bill requires a hospital to notify each obstetrical physician with privileges at the facility at least 90 days before it closes its obstetrical department or ceases to provide obstetrical services. The bill also repeals a provision designating certain hospitals as "provider hospitals," which have special requirements for cesarean section operations that are paid for with state or federal funds.

Most of the bill becomes effective upon becoming a law. However, the authority for a PA or an ARNP to prescribe controlled substances in accordance with the bill becomes effective January 1, 2017.

II. Present Situation:

Unlike all other states, Florida does not allow ARNPs to prescribe controlled substances and is one of two states that does not allow PAs to prescribe controlled substances.[1] The states have varying permissions with respect to the Schedules[2] from which an ARNP or PA may prescribe as well as the additional functions, such as dispensing, administering, or handling samples, that an ARNP or PA may perform.

According to a recent study commissioned by the Safety Net Hospital Alliance of Florida,[3] Florida's total current supply of primary care physicians falls short of the number needed to provide a national average level of care by approximately 6 percent. Under a traditional definition of primary care specialties (i.e., general and family practice, general internal medicine, general pediatrics and geriatric medicine) supply falls short of demand by approximately 3 percent. Based on simulation models, the report concludes that over the next several years, this shortfall will grow slightly as more people obtain insurance coverage as mandated by the federal Affordable Care Act. However, if current trends continue, this shortfall should disappear within a decade. Even if the statewide supply of primary care physicians is adequate to provide a national average level of care, there is substantial geographic variation in adequacy of care.

Regulation of Physician Assistants in Florida

Chapter 458, F.S., sets forth the provisions for the regulation of the practice of allopathic medicine by the Board of Medicine (BOM). Chapter 459, F.S., similarly sets forth the provisions for the regulation of the practice of osteopathic medicine by the Board of Osteopathic Medicine (BOOM). PAs are regulated by both boards. Licensure of PAs is overseen jointly by the boards

[1] DEA Diversion Control, U.S. Department of Justice, *Mid-Level Practitioners Authorization by State*, (last updated Nov. 10, 2015), *available at* http://www.deadiversion.usdoj.gov/drugreg/practioners/mlp_by_state.pdf, (last visited Dec. 3, 2015). Kentucky does not allow PAs to prescribe controlled substances.
[2] Controlled substances are assigned to Schedules I - V based on their accepted medical use and potential for abuse.
[3] IHS Global Inc., *Florida Statewide and Regional Physician Workforce Analysis: Estimating Current and Forecasting Future Supply and Demand*, (January 28, 2015), https://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/GME/docs/FINAL_Florida_Statewide_and_Regional_Physician_Workforce_Analysis.pdf, (last visited Dec. 3, 2015).

through the Council on Physician Assistants.[4] During the 2014-2015 state fiscal year, there were 6,744 in-state, actively licensed PAs in Florida.[5]

PAs are trained and required by statute to work under the supervision and control of allopathic or osteopathic physicians.[6] The BOM and the BOOM have adopted rules that set out the general principles a supervising physician must use in developing the scope of practice of the PA under both direct[7] and indirect[8] supervision. A supervising physician's decision to permit a PA to perform a task or procedure under direct or indirect supervision must be based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient. The supervising physician must be certain that the PA is knowledgeable and skilled in performing the tasks and procedures assigned.[9] Each physician, or group of physicians supervising a licensed PA, must be qualified in the medical areas in which the PA is to work and is individually or collectively responsible and liable for the performance and the acts and omissions of the PA.[10]

Current law allows a supervisory physician to delegate authority to prescribe or dispense any medication used in the physician's practice, except controlled substances, general anesthetics, and radiographic contrast materials.[11] However, the law allows a supervisory physician to delegate authority to a PA to order any medication, which would include controlled substances, general anesthetics, and radiographic contrast materials, for a patient of the physician during the patient's stay in a facility licensed under ch. 395, F.S.[12]

Regulation of Advanced Registered Nurse Practitioners in Florida

Chapter 464, F.S., governs the licensure and regulation of nurses in Florida. Nurses are licensed by the Department of Health (DOH) and are regulated by the Board of Nursing (BON).[13] During the 2014-2015 state fiscal year, there were 18,276 in-state, actively licensed ARNPs in Florida.[14]

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[4] The council consists of three physicians who are members of the Board of Medicine; one physician who is a member of the Board of Osteopathic Medicine; and a physician assistant appointed by the State Surgeon General. (s. 458.348(9), F.S. and s. 459.022(9), F.S.)

[5] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan Fiscal Year 2014-2015*, p. 11, available at: http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1415.pdf , (Last visited Dec. 7, 2015).

[6] Sections 458.347(4), and 459.022(4), F.S.

[7] "Direct supervision" requires the physician to be on the premises and immediately available. (*See* Rules 64B8-30.001(4) and 64B15-6.001(4), F.A.C.).

[8] "Indirect supervision" requires the physician to be within reasonable physical proximity. (Rules 64B8-30.001(5) and 64B15-6.001(5), F.A.C.

[9] Rules 64B8-30.012(2) and 64B15-6.010(2), F.A.C.

[10] Sections 458.347(3) and (15) and 459.022(3) and (15), F.S.

[11] Sections 458.347(4)(e) and (f)1., and 459.022(4)(e)., F.S.

[12] *See* s. 395.002(16), F.S. The facilities licensed under chapter 395 are hospitals, ambulatory surgical centers, and mobile surgical facilities.

[13] The BON is comprised of 13 members appointed by the Governor and confirmed by the Senate who serve 4-year terms. Seven of the 13 members must be nurses who reside in Florida and have been engaged in the practice of professional nursing for at least 4 years. Of those seven members, one must be an advanced registered nurse practitioner, one a nurse educator at an approved nursing program, and one a nurse executive. Three members of the BON must be licensed practical nurses who reside in the state and have engaged in the practice of practical nursing for at least 4 years. The remaining three members must be Florida residents who have never been licensed as nurses and are in no way connected to the practice of nursing, any health care facility, agency, or insurer. Additionally, one member must be 60 years of age or older. *See* s. 464.004(2), F.S.

[14] *Supra* note 5. Certified Nurse Specialists account for 26 of the in-state actively licensed ARNPs.

An ARNP is a licensed nurse who is certified in advanced or specialized nursing.[15] Florida recognizes three types of ARNPs: nurse practitioners (NP), certified registered nurse anesthetists (CRNA), and certified nurse midwives (CNM).[16] To be certified as an ARNP, a nurse must hold a current license as a registered nurse[17] and submit proof to the BON that the ARNP applicant meets one of the following requirements:[18]

- Satisfactory completion of a formal postbasic educational program of specialized or advanced nursing practice;
- Certification by an appropriate specialty board;19 or
- Completion of a master's degree program in the appropriate clinical specialty with preparation in specialty-specific skills.

Advanced or specialized nursing acts may only be performed under the protocol of a supervising physician or dentist. Within the established framework of the protocol, an ARNP may:[20]

- Monitor and alter drug therapies;
- Initiate appropriate therapies for certain conditions; and
- Order diagnostic tests and physical and occupational therapy.

The statute further describes additional acts that may be performed within an ARNP's specialty certification (CRNA, CNM, and NP).[21]

An ARNP must meet financial responsibility requirements, as determined by rule of the BON, and the practitioner profiling requirements.[22] The BON requires professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 or an unexpired irrevocable letter of credit in the same amounts payable to the ARNP.[23]

Florida does not allow ARNPs to prescribe controlled substances.[24] However, s. 464.012(4)(a), F.S., provides express authority for a CRNA to order certain controlled substances "to the extent authorized by the established protocol approved by the medical staff of the facility in which the anesthetic service is performed."

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[15] "Advanced specialized nursing practice" is defined as the performance of advanced-level nursing acts approved by the Board of Nursing, which, by virtue of postbasic specialized education, training and experience, are appropriately performed by an advanced registered nurse practitioner. (*See* s. 464.003(2), F.S.)

[16] Section 464.003(3), F.S. Florida certifies clinical nurse specialists as a category distinct from advanced registered nurse practitioners. (*See* ss. 464.003(7) and 464.0115, F.S.).

[17] Practice of professional nursing. (*See* s. 464.003(20), F.S.)

[18] Section 464.012(1), F.S.

[19] Specialty boards expressly recognized by the Board of Nursing include: Council on Certification of Nurse Anesthetists, or Council on Recertification of Nurse Anesthetists; American College of Nurse Midwives; American Nurses Association (American Nurses Credentialing Center); National Certification Corporation for OB/GYN, Neonatal Nursing Specialties; National Board of Pediatric Nurse Practitioners and Associates; National Board for Certification of Hospice and Palliative Nurses; American Academy of Nurse Practitioners; Oncology Nursing Certification Corporation; American Association of Critical-Care Nurses Adult Acute Care Nurse Practitioner Certification. (Rule 64B9-4.002(2), F.A.C.)

[20] Section 464.012(3), F.S.

[21] Section 464.012(4), F.S.

[22] Sections 456.0391 and 456.041, F.S.

[23] Rule 64B9-4.002(5), F.A.C.

[24] Sections 893.02(21) and 893.05(1), F.S.

Educational Preparation

Physician Assistants[25]

PA education is modeled on physician education. PA programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant. All PA programs must meet the same set of national standards for accreditation. PA program applicants must complete at least 2 years of college courses in basic science and behavioral science as a prerequisite to PA training. The average length of PA education programs is about 26 months. Students begin their course of study with a year of basic medical science classes (anatomy, pathophysiology, pharmacology, physical diagnosis, etc.) Then the PA students enter the clinical phase of training, which includes classroom instruction and clinical rotations in medical and surgical specialties. PA students, on average, complete 48.5 weeks of supervised clinical practice by the time they graduate.

All PA educational programs include pharmacology courses, and nationally, the average amount of required formal classroom instruction in pharmacology is 75 hours. This does not include instruction in pharmacology that students receive during clinical medicine coursework and clinical clerkships. Based on national data, the mean amount of total instruction in clinical medicine is 358.9 hours. And the average length of required clinical clerkships is 48.5 weeks. A significant percentage of time is focused on patient management, including pharmacotherapeutics. Coursework in pharmacology addresses, but is not limited to, pharmacokinetics, drug interactions, adverse effects, contraindications, indications, and dosage.

Advanced Registered Nurse Practitioners[26]

Applicants for Florida licensure who graduated on or after October 1, 1998, must have completed requirements for a master's degree or post-master's degree.[27] Applicants who graduated before that date, may be or may have been eligible through a certificate program.[28]

The curriculum of a program leading to an advanced degree must include, among other things:

- Theory and directed clinical experience in physical and biopsychosocial assessment.
- Interviewing and communication skills relevant to obtaining and maintaining a health history;
- Pharmacotherapeutics, including selecting, prescribing, initiating, and modifying medications in the management of health and illness;
- Selecting, initiating and modifying diets and therapies in the management of health and illness;
- Performance of specialized diagnostic tests that are essential to the area of advanced practice;
- Differential diagnosis pertinent to the specialty area;
- Interpretation of laboratory findings;
- Management of selected diseases and illnesses;

[25] *See* American Academy of Physician Assistants, *PAs as Prescribers of Controlled Medications – Issue Brief*, (June 2014), available at: https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=2549 (last viewed Dec. 3, 2015).
[26] Rule 64B9-4.003, F.A.C.
[27] Florida Board of Nursing, *ARNP Licensure Requirements* http://floridasnursing.gov/licensing/advanced-registered-nurse-practitioner/, (last visited Dec. 3, 2015).
[28] *Id.*, and s. 464.012(1), F.S.

- Professional socialization and role realignment;
- Legal implications of the advanced nursing practice and nurse practitioner role;
- Health delivery systems, including assessment of community resources and referrals to appropriate professionals or agencies; and
- Providing emergency treatments.

The program must provide a minimum of 500 hours (12.5 weeks) of preceptorship/supervised clinical experience[29] in the performance of the specialized diagnostic procures that are essential to practice in that specialty area.

Drug Enforcement Agency Registration

The Drug Enforcement Agency (DEA) registration grants practitioners federal authority to handle controlled substances. However, the DEA registered practitioner may only engage in those activities that are authorized under state law for the jurisdiction in which the practice is located.[30]

According to requirements of the DEA, a prescription for a controlled substance may only be issued by a physician, dentist, podiatrist, veterinarian, mid-level practitioner,[31] or other registered practitioner who is:

- Authorized to prescribe controlled substances by the jurisdiction in which the practitioner is licensed to practice;
- Registered with DEA or exempted from registration (that is, Public Health Service, Federal Bureau of Prisons, or military practitioners); or
- An agent or employee of a hospital or other institution acting in the normal course of business or employment under the registration of the hospital or other institution which is registered in lieu of the individual practitioner being registered provided that additional requirements are met.[32] These requirements include:
- The dispensing, administering, or prescribing is in the usual course of professional practice;
- The practitioner is authorized to do so by the state in which he or she practices;
- The hospital or other institution has verified that the practitioner is permitted to administer, dispense, or prescribe controlled substances within the state;
- The practitioner acts only within the scope of employment in the hospital or other institution;
- The hospital or other institution authorizes the practitioner to administer, dispense, or prescribe under its registration and assigns a specific internal code number for each practitioner; and
- The hospital or other institution maintains a current list of internal codes and the corresponding practitioner.[33]

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[29] Preceptorship/supervised clinical experience must be under the supervision of a qualified preceptor, who is defined as a practicing certified ARNP, a licensed medical doctor, osteopathic physician, or a dentist. *See* Rule 64B9-4.001(13), F.A.C.
[30] U.S. Department of Justice, Drug Enforcement Administration, *Practitioner's Manual*, (August 2006), p. 7, *available at* http://www.deadiversion.usdoj.gov/pubs/manuals/pract/pract_manual012508.pdf (last visited Dec. 3, 2015).
[31] Examples of mid-level practitioners include, but are not limited to: nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists, and physician assistants.
[32] *Supra* note 30, at p.18.
[33] *Supra* note 30, at p.12.

Peer Review of Publically Funded C-Sections

Section 383.336, F.S., relates to public health and maternal and infant health care where all or part of the costs are paid for by state or federal funds administered by the state. It defines a "provider hospital" as one in which there are 30 or more births per year paid for in part, or in full, by state or federal funds. It directs the State Surgeon General, in consultation with the Board of Medicine and the Florida Obstetric and Gynecologic Society, to establish practice parameters for physicians in provider hospitals who perform caesarean sections; and requires each provider hospital to establish a peer review board to conduct monthly reviews of every publically funded caesarean section performed since the previous review.

Beginning in 2014, hospitals that are accredited by the Joint Commission and which performed more than 1,100 births per year were required to report on certain cesarean sections performed in the hospital as a part of their perinatal core measure set. Effective with January 1, 2016 discharges, the threshold for mandatory reporting is reduced to hospitals with 300 or more births per year. Each hospital receives a quarterly risk-adjusted performance report with their hospital's C-section rate compared to a desired target range.[34]

The Patient Protection and Affordable Care Act

In March 2010, the Congress passed and President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA).[35] Among its changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers. Coverage is available through an employer, the federal or state exchanges created under PPACA, or off the exchange, that meets the federal essential health benefits requirements. Florida did not establish its own state exchange under PPACA. Premium credits and other cost sharing subsidies are available to U.S. citizens and legal immigrants within certain income limits for qualified coverage purchased through the exchange.[36]

Nonpayment of Premium

Federal regulations for PPACA also govern an enrollee's coverage bought through the exchanges and for non-grandfathered plans.[37] If an exchange enrollee received an advance premium tax credit for a qualified health plan (QHP)[38] and paid at least one full month's premium during the

[34] *See* Expanded threshold for reporting Perinatal Care measure set, a Joint Commission Article published on June 24, 2015, available at: http://www.jointcommission.org/issues/article.aspx?Article=A9Im9xfNbBo97ZcgWQAj/SE KRiZJsPtdFLyHUR1bZU= (last visited Jan. 6, 2016). *See also* U.S. Hospitals Held Accountable for C-Section Rates by Rebecca Dekker, PhD, RN, APRN of www.evidencebasedbirth.com, available at: http://improvingbirth.org/2013/01/u-s-hospitals-held-accountable-for-c-section-rates/ (last visited Jan. 6, 2016).

[35] P.L. 111-148. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.

[36] Centers for Medicare and Medicaid Services, *Health Insurance Marketplace - Will I Qualify for Lower Costs on Monthly Premiums?* https://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/ (last visited Jan. 23, 2016).

[37] Certain plans received "grandfather status" under PPACA. A grandfathered health plan is a plan that existed on March 23, 2010, and had at least one person continuously covered for 1 year. Some consumer protections elements do not apply to grandfathered plans.

[38] A "qualified health plan" is an insurance plan certified by the applicable Health Insurance Marketplace, provides the essential health benefits, established limits on cost sharing and meets other requirements. *See*

benefit year, and is terminated for non-payment of premium, the insurer must provide the enrollee a 3-month grace period before cancellation of coverage.[39] During the grace period, the insurer must pay claims for services rendered in the first month but may pend claims for the second and third months.[40] The insurer is also required to notify providers of the possibility for denied claims when an enrollee is in the second or third months of the grace period. The insurer is also required to provide the enrollee with notice of such payment delinquency. If an insurer terminates an enrollee's coverage after the 3-month grace period, the insurer must provide written notice of termination 14 days before the effective date. If coverage is terminated, the termination date is the last day of the first month of the 90-day grace period and the insurer may not recoup any claims paid during the first month of the grace period.

The federal regulations do not affect those enrollees who are not enrolled in an exchange plan or do not receive a subsidy. The grace period for these individuals remains at the length required under s. 627.608, F.S., which varies by the length of the premium payment interval. Cancellation of coverage is effective the first day of the grace period if payment is not received.

Retroactive Denial of Claims by Health Insurers

Section 627.6131, F.S., and s. 641.3155, F.S., prohibit a health insurer and HMO, respectively, from retroactively denying a claim because of insured ineligibility more than 1 year after the date the claim is paid. There is, however, no redress for erroneous authorization and an insured's reliance on that authorization.

III. Effect of Proposed Changes:

ARNP and PA Authorized to Prescribe Controlled Substances

CS/SB 676 authorizes PAs licensed under the Medical Practice Act or the Osteopathic Medical Practice Act, and ARNPs certified under part I of the Nurse Practice Act, to prescribe controlled substances under current supervisory standards for PAs and protocols for ARNPs beginning January 1, 2017; and it creates additional statutory parameters on their controlled substance prescribing. Specifically, an ARNP's and PA's prescribing privileges, for controlled substances listed on Schedule II, are limited to a 7-day supply, do not include prescribing psychotropic medications for children under 18 years of age except by an ARNP who is also a psychiatric nurse as defined by s. 394.455, F.S.,[41] and may be limited by the controlled substance formularies themselves which impose additional limitations on PA or ARNP prescribing privileges for specific medications. (Sections 12 – 15)

For PAs, the bill creates the ability to prescribe controlled substances by removing controlled substances from the formulary of medicinal drugs that a PA may not prescribe in the Medical

https://www.healthcare.gov/glossary/qualified-health-plan/ for more information on qualified health plans (last visited Jan. 23, 2016).

[39] 45 CFR 156.270 and 45 CFR 430.

[40] 45 CFR 156.270.

[41] Section 394.55(23), F.S., defines a "psychiatric nurse" as an advanced registered nurse practitioner certified under s. 464.012, F.S., who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has 2 years of post-master's clinical experience under the supervision of a physician.

Practice Act. The Osteopathic Medical Practice Act refers to the formulary in the Medical Practice Act, so no changes are made to that act. (Section 12)

For ARNPs, the authorization to prescribe controlled substances is accomplished by revising the authority pertaining to drug therapies. The bill authorizes an ARNP to prescribe, dispense, administer, or order any drug, which would include controlled substances. However, a master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills is required to prescribe or dispense controlled substances. (Section 15)

Additionally, CS/SB 676, adds an ARNP and PA to the definition of practitioner in ch. 893, F.S. This definition requires the practitioner to hold a valid federal controlled substance registry number. (Section 21).

The bill requires the appointment of a committee[42] to recommend an evidence-based formulary of controlled substances (controlled substances formulary) that an ARNP may not prescribe, or may prescribe under limited circumstances, as needed to protect the public interest. The committee may recommend a controlled substances formulary applicable to all ARNPs that may be limited by specialty certification, approved uses of controlled substances, or other similar restrictions deemed necessary to protect the public interest. At a minimum, the formulary must restrict the prescribing of psychiatric mental health controlled substances for children under 18 years of age to psychiatric nurses as defined in the Baker Act.[43] The formulary must also limit the prescribing of controlled substances in Schedule II to a 7-day supply, similar to the limitation imposed for PAs, except this limitation does not apply to a psychiatric medication prescribed by a psychiatric nurse under the Baker Act. (Section 14)

The committee formed to recommend the controlled substances formulary is a replacement to a joint committee that was established in law for other purposes but which has been dormant for many years. Language establishing the joint committee and references to it are removed from law in Sections 13, 23, and 24 of the bill.

The formulary committee consists of three Florida-certified ARNPs who are recommended by the BON, three physicians licensed under ch. 458 or ch. 459 who have had work experience with ARNPs and who are recommended by the Board of Medicine, and a Florida-licensed pharmacist who holds a Doctor of Pharmacy degree and is recommended by the Board of Pharmacy.

The BON is to establish the controlled substances formulary for ARNPs by January 1, 2017. The bill requires the board to adopt recommendations for the formulary that are made by the committee and which are supported by evidence-based clinical findings presented by the Board of Medicine, the Board of Osteopathic Medicine, or the Board of Dentistry. The BON is required to adopt the formulary committee's initial recommendation by October 31, 2016.

[42] The committee membership is: three ARNPs, including a certified registered nurse anesthetist, a certified nurse midwife, and a nurse practitioner; at least one physician recommended by the Board of Medicine and one physician recommended by the Board of Osteopathic Medicine, who have experience working with APRNs; and a pharmacist licensed under ch. 465, F.S., who is not also licensed as a physician under ch. 458, F.S., an osteopathic physician under ch. 459, F.S., or an ARNP under ch. 464, F.S. The committee members are selected by the State Surgeon General.

[43] The Baker Act is also known as the Florida Mental Health Act and the definition of a psychiatric nurse is found in s. 394.455, F.S.

The controlled substances formulary adopted by board rule does not apply to the following acts performed within the ARNP's specialty under the established protocol approved by the medical staff of the facilities in which the service is performed, which are currently authorized under s. 464.012(4)(a)3., 4., and 9., F.S:

- Orders for pre-anesthetic medications;
- Ordering and administering regional, spinal, and general anesthesia, inhalation agents and techniques, intravenous agents and techniques, hypnosis, and other protocol procedures commonly used to render the patient insensible to pain during surgical, obstetrical, therapeutic, or diagnostic clinical procedures; or
- Managing a patient while in the postanesthesia recovery area.

CS/SB 676 requires a PA and ARNP to have three hours of continuing education on the safe and effective prescription of controlled substances and specifies several statutorily pre-approved providers of those continuing education hours. (Sections 11 and 16)

A PA or ARNP who prescribes controlled substances that are listed in Schedule II, Schedule III, or Schedule IV, for the treatment of chronic nonmalignant pain is required to designate himself or herself as a controlled substance prescribing practitioner on his or her respective practitioner profile maintained by the DOH. Currently, PAs do not have practitioner profiles so the DOH will need to develop a profile for PAs to comply with this requirement. (Section 8)

The bill imposes the same disciplinary standards on PAs and ARNPs as those applicable to physicians for failing to meet minimal standards of acceptable and prevailing practice in prescribing and dispensing of controlled substances.

ARNP disciplinary sanctions are added to the bill in s. 456.072, F.S., (Section 7) to mirror a physician's sanctions for prescribing or dispensing a controlled substance other than in the course of professional practice or failing to meet practice standards. Additional acts for which discipline may be taken against an ARNP relating to practicing with controlled substances that are added to the Nurse Practice Act (Section 17) include:

- Pre-signing blank prescription forms;
- Prescribing for office use any medicinal drug appearing on Schedule II in chapter 893.
- Prescribing, ordering, dispensing, administering, supplying, selling, amphetamines, sympathomimetic amines, or a compound designated in s. 893.03(2), F.S., as a Schedule II controlled substance, to anyone except for:
    - Treating narcolepsy,[44] hyperkinesis,[45] behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short

[44] *Narcolepsy* is a medical condition in which someone suddenly falls into a deep sleep while talking, working, *etc.* Miriam-Webster Dictionary, Encyclopedia Britannica Company, *available at*: http://www.merriam-webster.com/dictionary/narcolepsy, (Last visited Dec. 7, 2015).

[45] *Hyperkinesis* is defined as an abnormally increased and sometimes uncontrollable activity or muscular movements; 2. a condition especially of childhood characterized by hyperactivity. Miriam-Webster Dictionary, Encyclopedia Britannica Company, *available at*: http://www.merriam-webster.com/dictionary/hyperkinesis, (Last visited Dec. 7, 2015).

attention span, hyperactivity, emotional lability,[46] and impulsivity; or drug-induced brain dysfunction;
    - The diagnostic and treatment of depressions; and
    - Clinical investigations which have been approved by the department before such investigation is begun.
- Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance;[47]
- Promoting or advertising on any prescription form a community pharmacy unless the form also states: "This prescription may be filled at any pharmacy of your choice";
- Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the ARNP by another practitioner authorized to prescribe, dispense, or administer medicinal drugs;
- Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person;[48]
- Dispensing a substance controlled in Schedule II or Schedule III, in violation of s. 465.0276, F.S.; and
- Promoting or advertising through any communication medium the use, sale, or dispensing of a substance designated in s. 893.03, F.S., as a controlled substance.

Disciplinary standards that are applicable to physicians are already applicable to PAs pursuant to ss. 458.347(7)(g) and 459.022(7)(g), F.S., so no additional amendments are needed for disciplinary and enforcement action for violations of the applicable practice act relating to controlled substances.

The statutes regulating pain-management clinics under the Medical Practice Act and the Osteopathic Medical Practice Act are amended to limit the prescribing of controlled substances in a pain-management clinic to physicians licensed under ch. 458, F.S., or ch. 459, F.S. Accordingly, PAs and ARNPs are prohibited from prescribing controlled substances in pain-management clinics. (Sections 9 and 10)

Under current law, a medical specialist who is board certified or board eligible in pain medicine by certain boards is exempted from the statutory standards of practice in s. 456.44, F.S., relating to prescribing controlled substances for the treatment of chronic nonmalignant pain. Two additional boards are added to that list; the boards are the American Board of Interventional Pain Physicians and the American Association of Physician Specialists. (Section 8).

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[46] *Emotional lability* is a condition of excessive emotional reactions and frequent mood changes. Mosby's Medical Dictionary, 9th edition. 2009, Elsevier, *available at*: http://medical-dictionary.thefreedictionary.com/emotional+lability , (Last visited Dec. 7, 2015).

[47] Bill section 17 amends s. 464.018, F.S., to add subpart (1)(p)4., which prohibits the prescribing of certain hormones for the purpose of "muscle building"; but excludes the treatment of an injured muscle from the definition of "muscle building" as used in this section; and pharmacists receiving prescriptions for the listed hormones may dispense them with the presumption that the prescription is for legitimate medical use.

[48] Laetrile is an allegedly antineoplastic drug consisting chiefly of amygdalin derived from apricot pits. It has not been proven to have any beneficial use. Farlex Partner Medical Dictionary Farlex 2012, *available at*: http://medical-dictionary.thefreedictionary.com/laetrile, (Last visited Dec. 7, 2015).

Sections 1 – 4, and 22 of the bill amend various statutes to authorize or recognize that a PA or an ARNP may be a prescriber of controlled substances as follows:

- Section 110.12315, F.S., relating to the state employees' prescription drug program, authorizes ARNPs and PAs to prescribe brand name drugs which are medically necessary or are included on the formulary of drugs which may not be interchanged. (Section 1)
- Section 310.071, F.S., relating to deputy pilot certification; s. 310.073, F.S., relating to state pilot licensing; and s. 310.081, F.S., relating to licensed state pilots and certified deputy pilots, allows the presence of a controlled substance in a pilot's drug test results, which was prescribed by an ARNP or PA whose care the pilot is under, as a part of the annual physical examination required for initial certification, initial licensure, and certification and licensure retention. (Sections 2, 3, and 4)
- Section 948.03, F.S., relating to terms and conditions of criminal probation, includes an ARNP and PA as an authorized prescriber of drugs or narcotics that a person on probation may lawfully possess. (Section 22)

Hospital Regulation

The bill requires a hospital to notify each obstetrical physician with privileges at the facility at least 90 days before it closes its obstetrical department or ceases to provide obstetrical services. (Section 6)

The bill also repeals a provision designating certain hospitals as "provider hospitals," which have special requirements for cesarean section operations that are paid for with state or federal funds, including a peer review board that reviews the procedures performed and establishes practice parameters for such operations. (Section 5)

Prior Authorization Forms

CS/SB 676 creates s. 627.42392, F.S., to require insurers, Medicaid managed care plans, health maintenance organizations, or their pharmacy benefits managers, that do not use electronic prior authorization forms for their contract providers, to only use prior authorization forms approved by the Financial Services Commission in consultation with the Agency for Health Care Administration to obtain prior authorization for medical procedures, courses of treatment, and prescription drugs beginning January 1, 2017. The Commission in consultation with the agency must adopt by rule guidelines for these forms to ensure general uniformity of the forms; and the forms may not exceed two pages, excluding instructions. (Section 18)

Retroactive Denial of Claims

CS/SB 676 amends ss. 627.6131 and 641.3155, F.S., to preclude a health insurer or an HMO from retroactively denying a claim because of an insured's ineligibility after the health insurer or HMO has previously verified eligibility at the time of treatment and provided an authorization number. (Sections 19 and 20)

Technical Revisions and Effective Date

Sections 25 –33 reenact multiple statutes for the purpose of incorporating the amendments made by the bill to ss. 456.072, 456.44, 458.347, 464.003, 464.012, 464.013, 464.018, 893.02, and 948.03, F.S., in references thereto.

Additional conforming and grammatical changes are made in the bill.

Most of the bill becomes effective upon becoming law. However, the authority for a PA or an ARNP to prescribe controlled substances in accordance with the bill becomes effective January 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

PAs and ARNPs who are authorized by the supervising physician or under a protocol to prescribe controlled substances may be able to care for more patients due to reduced coordination with the supervising physician each time a controlled substance is recommended for a patient. Patients may see reduced health care costs and efficiencies in health care delivery as a result of having their health care needs more fully addressed by the PA or ARNP without specific involvement of a physician prescribing a needed controlled substance for treatment. Any such impacts are indeterminate.

Eliminating the ability of a health insurer or HMO to subsequently deny a claim once authorized will avoid unanticipated additional financial obligations to a patient and potential unexpected loss of revenues to healthcare providers.

Limiting paper prior authorization forms to a single format may expedite completion of the forms and promote efficiencies in a medical practice.

C. Government Sector Impact:

The DOH may incur costs for rulemaking, modifications to develop a profile for PAs, and workload impacts related to additional complaints and investigations.

VI. Technical Deficiencies:

Section 18, which amends the Insurance Code, requires a health insurer, or a pharmacy benefit managers (PBMs) acting on behalf of the health insurer, which does not use an electronic prior authorization form for its network providers to use the prior authorization form that the Financial Services Commission in consultation with the agency adopts by rule. Further, the commission in consultation with the agency is required to adopt by rule guidelines for all prior authorization forms. The Office of Insurance Regulation does not regulate pharmacy benefit managers. Insurers and HMOs, and other risk bearing entities that are regulated by the OIR, who contract with a PBM or other third party, are subject to this statutory provision and would be subject to enforcement by the OIR for noncompliance.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 110.12315, 310.071, 310.073, 310.081, 395.1051, 456.072, 456.44, 458.3265, 459.0137, 458.347, 464.003, 464.012, 464.013, 464.018, 627.6131, 641.3155, 893.02, 948.03, 458.348, 459.025, 458.331, 459.015, 459.022, 465.0158, 466.02751, 458.303, 458.3475, 459.023, 456.041, 464.012, 464.0205, 320.0848, 464.008, 464.009, 775.051, 893.02, 944.17, 948.001, 948.03, 948.101

This bill creates section 627.42392 of the Florida Statutes.

This bill repeals section 383.336 of the Florida Statutes.

IX. Additional Information:

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

CS/CS by Banking and Insurance on January 26, 2016:
The CS/CS provides that the Financial Services Commission in consultation with the Agency for Health Care Administration will adopt by rule a prior authorization form and guidelines. The CS also corrects a cross reference.

CS by Health Policy on January 11, 2016:
The CS amends SB 676 to add the American Association of Nurse Anesthetists to the list of statutorily pre-approved providers for continuing education for ARNPs.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/27/2016	.	
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The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment (with title amendment)

Delete lines 928 - 942

and insert:

in s. 624.603, a managed care plan as defined in s. 409.962(9), or a health maintenance organization as defined in s. 641.19(12).

(2) Notwithstanding any other provision of law, in order to establish uniformity in the submission of prior authorization forms on or after January 1, 2017, a health insurer, or a

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pharmacy benefits manager on behalf of the health insurer, which does not use an electronic prior authorization form for its contracted providers shall use only the prior authorization form that has been approved by the Financial Services Commission in consultation with the Agency for Health Care Administration to obtain a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation.

(3) The Financial Services Commission in consultation with the Agency for Health Care Administration shall adopt by rule

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 65 - 66

and insert:

approved by the Financial Services Commission in consultation with the Agency for Health Care Administration; requiring the commission in consultation with the agency to adopt by rule guidelines

By the Committee on Health Policy; and Senator Grimsley

588-02033-16 2016676c1

A bill to be entitled

An act relating to access to health care services; amending s. 110.12315, F.S.; expanding the categories of persons who may prescribe brand name drugs under the prescription drug program when medically necessary; amending ss. 310.071, 310.073, and 310.081, F.S.; exempting controlled substances prescribed by an advanced registered nurse practitioner or a physician assistant from the disqualifications for certification or licensure, and for continued certification or licensure, as a deputy pilot or state pilot; repealing s. 383.336, F.S., relating to provider hospitals, practice parameters, and peer review boards; amending s. 395.1051, F.S.; requiring a hospital to provide specified advance notice to certain obstetrical physicians before it closes its obstetrical department or ceases to provide obstetrical services; amending s. 456.072, F.S.; applying existing penalties for violations relating to the prescribing or dispensing of controlled substances by an advanced registered nurse practitioner; amending s. 456.44, F.S.; defining the term "registrant"; deleting an obsolete date; requiring advanced registered nurse practitioners and physician assistants who prescribe controlled substances for the treatment of certain pain to make a certain designation, comply with registration requirements, and follow specified standards of practice; providing applicability; amending ss. 458.3265 and 459.0137, F.S.; limiting the authority to prescribe a controlled substance in a pain-management clinic only to a physician licensed under ch. 458 or ch. 459, F.S.; amending s. 458.347, F.S.; revising the

588-02033-16 2016676c1

required continuing education requirements for a physician assistant; requiring that a specified formulary limit the prescription of certain controlled substances by physician assistants as of a specified date; amending s. 464.003, F.S.; revising the term "advanced or specialized nursing practice"; deleting the joint committee established in the definition; amending s. 464.012, F.S.; requiring the Board of Nursing to establish a committee to recommend a formulary of controlled substances that may not be prescribed, or may be prescribed only on a limited basis, by an advanced registered nurse practitioner; specifying the membership of the committee; providing parameters for the formulary; requiring that the formulary be adopted by board rule; specifying the process for amending the formulary and imposing a burden of proof; limiting the formulary's application in certain instances; requiring the board to adopt the committee's initial recommendations by a specified date; authorizing an advanced registered nurse practitioner to prescribe, dispense, administer, or order drugs, including certain controlled substances under certain circumstances, as of a specified date; amending s. 464.013, F.S.; revising continuing education requirements for renewal of a license or certificate; amending s. 464.018, F.S.; specifying acts that constitute grounds for denial of a license or for disciplinary action against an advanced registered nurse practitioner; creating s. 627.42392,

F.S.; defining the term "health insurer"; requiring that certain health insurers that do not already use a certain form use only a prior authorization form approved by the Financial Services Commission; requiring the commission to adopt by rule guidelines for such forms; amending s. 627.6131, F.S.; prohibiting a health insurer from retroactively denying a claim under specified circumstances; amending s. 641.3155, F.S.; prohibiting a health maintenance organization from retroactively denying a claim under specified circumstances; amending s. 893.02, F.S.; revising the term "practitioner" to include advanced registered nurse practitioners and physician assistants under the Florida Comprehensive Drug Abuse Prevention and Control Act if a certain requirement is met; amending s. 948.03, F.S.; providing that possession of drugs or narcotics prescribed by an advanced registered nurse practitioner or a physician assistant does not violate a prohibition relating to the possession of drugs or narcotics during probation; amending ss. 458.348 and 459.025, F.S.; conforming provisions to changes made by the act; reenacting ss. 458.331(10), 458.347(7)(g), 459.015(10), 459.022(7)(f), and 465.0158(5)(b), F.S., to incorporate the amendment made to s. 456.072, F.S., in references thereto; reenacting ss. 456.072(1)(mm) and 466.02751, F.S., to incorporate the amendment made to s. 456.44, F.S., in references thereto; reenacting ss. 458.303, 458.3475(7)(b), 459.022(4)(e) and (9)(c),

and 459.023(7)(b), F.S., to incorporate the amendment made to s. 458.347, F.S., in references thereto; reenacting s. 464.012(3)(c), F.S., to incorporate the amendment made to s. 464.003, F.S., in a reference thereto; reenacting ss. 456.041(1)(a), 458.348(1) and (2), and 459.025(1), F.S., to incorporate the amendment made to s. 464.012, F.S., in references thereto; reenacting s. 464.0205(7), F.S., to incorporate the amendment made to s. 464.013, F.S., in a reference thereto; reenacting ss. 320.0848(11), 464.008(2), 464.009(5), and 464.0205(1)(b), (3), and (4)(b), F.S., to incorporate the amendment made to s. 464.018, F.S., in references thereto; reenacting s. 775.051, F.S., to incorporate the amendment made to s. 893.02, F.S., in a reference thereto; reenacting ss. 944.17(3)(a), 948.001(8), and 948.101(1)(e), F.S., to incorporate the amendment made to s. 948.03, F.S., in references thereto; providing effective dates.

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

Section 1. Subsection (7) of section 110.12315, Florida Statutes, is amended to read:

110.12315 Prescription drug program.—The state employees' prescription drug program is established. This program shall be administered by the Department of Management Services, according to the terms and conditions of the plan as established by the relevant provisions of the annual General Appropriations Act and implementing legislation, subject to the following conditions:

(7) The department shall establish the reimbursement schedule for prescription pharmaceuticals dispensed under the program. Reimbursement rates for a prescription pharmaceutical must be based on the cost of the generic equivalent drug if a generic equivalent exists, unless the physician, advanced registered nurse practitioner, or physician assistant prescribing the pharmaceutical clearly states on the prescription that the brand name drug is medically necessary or that the drug product is included on the formulary of drug products that may not be interchanged as provided in chapter 465, in which case reimbursement must be based on the cost of the brand name drug as specified in the reimbursement schedule adopted by the department.

Section 2. Paragraph (c) of subsection (1) of section 310.071, Florida Statutes, is amended, and subsection (3) of that section is republished, to read:

310.071 Deputy pilot certification.—

(1) In addition to meeting other requirements specified in this chapter, each applicant for certification as a deputy pilot must:

(c) Be in good physical and mental health, as evidenced by documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician within the preceding 6 months. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a certificated deputy pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter

893 unless that individual is under the care of a physician, an advanced registered nurse practitioner, or a physician assistant and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant. To maintain eligibility as a certificated deputy pilot, each certificated deputy pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the certificateholder satisfactorily meets the standards. The standards for certificateholders shall include a drug test.

(3) The initial certificate issued to a deputy pilot shall be valid for a period of 12 months, and at the end of this period, the certificate shall automatically expire and shall not be renewed. During this period, the board shall thoroughly evaluate the deputy pilot's performance for suitability to continue training and shall make appropriate recommendations to the department. Upon receipt of a favorable recommendation by the board, the department shall issue a certificate to the deputy pilot, which shall be valid for a period of 2 years. The certificate may be renewed only two times, except in the case of a fully licensed pilot who is cross-licensed as a deputy pilot in another port, and provided the deputy pilot meets the requirements specified for pilots in paragraph (1)(c).

Section 3. Subsection (3) of section 310.073, Florida Statutes, is amended to read:

310.073 State pilot licensing.—In addition to meeting other requirements specified in this chapter, each applicant for license as a state pilot must:

(3) Be in good physical and mental health, as evidenced by documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician within the preceding 6 months. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a licensed state pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, an advanced registered nurse practitioner, or a physician assistant and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant. To maintain eligibility as a licensed state pilot, each licensed state pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the licensee satisfactorily meets the standards. The standards for licensees shall include a drug test.

Section 4. Paragraph (b) of subsection (3) of section 310.081, Florida Statutes, is amended to read:

310.081 Department to examine and license state pilots and certificate deputy pilots; vacancies.—

(3) Pilots shall hold their licenses or certificates pursuant to the requirements of this chapter so long as they:

(b) Are in good physical and mental health as evidenced by documentary proof of having satisfactorily passed a physical examination administered by a licensed physician or physician

assistant within each calendar year. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a licensed state pilot or a certificated deputy pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, an advanced registered nurse practitioner, or a physician assistant and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant. To maintain eligibility as a certificated deputy pilot or licensed state pilot, each certificated deputy pilot or licensed state pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the certificateholder or licensee satisfactorily meets the standards. The standards for certificateholders and for licensees shall include a drug test.

Upon resignation or in the case of disability permanently affecting a pilot's ability to serve, the state license or certificate issued under this chapter shall be revoked by the department.

Section 5. Section 383.336, Florida Statutes, is repealed.

Section 6. Section 395.1051, Florida Statutes, is amended to read:

395.1051 Duty to notify patients and physicians.—

(1) An appropriately trained person designated by each

licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care which ~~that~~ result in harm to the patient under this section does ~~shall~~ not constitute an acknowledgment or admission of liability and may not~~, nor can it~~ be introduced as evidence.

(2) A hospital shall notify each obstetrical physician who has privileges at the hospital at least 90 days before the hospital closes its obstetrical department or ceases to provide obstetrical services.

Section 7. Subsection (7) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(7) Notwithstanding subsection (2), upon a finding that a physician has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 458.331(1)(q) or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o) or (s), or s. 466.028(1)(p) or (x), or that an advanced registered nurse practitioner has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 464.018(1)(n) or (p)6., the physician or advanced registered nurse practitioner shall be suspended for a period of not less than 6 months and pay a fine of not less than $10,000 per count. Repeated violations shall result in increased penalties.

Section 8. Section 456.44, Florida Statutes, is amended to

read:

456.44 Controlled substance prescribing.—

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

(a) "Addiction medicine specialist" means a board-certified psychiatrist with a subspecialty certification in addiction medicine or who is eligible for such subspecialty certification in addiction medicine, an addiction medicine physician certified or eligible for certification by the American Society of Addiction Medicine, or an osteopathic physician who holds a certificate of added qualification in Addiction Medicine through the American Osteopathic Association.

(b) "Adverse incident" means any incident set forth in s. 458.351(4)(a)-(e) or s. 459.026(4)(a)-(e).

(c) "Board-certified pain management physician" means a physician who possesses board certification in pain medicine by the American Board of Pain Medicine, board certification by the American Board of Interventional Pain Physicians, or board certification or subcertification in pain management or pain medicine by a specialty board recognized by the American Association of Physician Specialists or the American Board of Medical Specialties or an osteopathic physician who holds a certificate in Pain Management by the American Osteopathic Association.

(d) "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

(e) "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

(f) "Mental health addiction facility" means a facility licensed under chapter 394 or chapter 397.

(g) "Registrant" means a physician, a physician assistant, or an advanced registered nurse practitioner who meets the requirements of subsection (2).

(2) REGISTRATION.—~~Effective January 1, 2012,~~ A physician licensed under chapter 458, chapter 459, chapter 461, or chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner certified under part I of chapter 464 who prescribes any controlled substance, listed in Schedule II, Schedule III, or Schedule IV as defined in s. 893.03, for the treatment of chronic nonmalignant pain, must:

(a) Designate himself or herself as a controlled substance prescribing practitioner on his or her ~~the physician's~~ practitioner profile.

(b) Comply with the requirements of this section and applicable board rules.

(3) STANDARDS OF PRACTICE.—The standards of practice in this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the

physical examination shall be left to the judgment of the registrant ~~clinician~~ who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient's risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient's risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant ~~physician~~ shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant ~~physician~~ shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient's surrogate or guardian if the patient is incompetent. The registrant ~~physician~~ shall use a written controlled substance agreement between the registrant ~~physician~~ and the patient outlining the patient's responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant ~~physician~~ unless otherwise authorized by the treating registrant ~~physician~~ and documented in the medical record.

(d) The patient shall be seen by the registrant ~~physician~~ at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's ~~physician's~~ evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant ~~physician~~ shall reevaluate the appropriateness of continued treatment. The registrant ~~physician~~ shall monitor patient

compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.

(e) The registrant ~~physician~~ shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or a psychiatrist.

(f) A registrant ~~physician registered under this section~~ must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.

2. Diagnostic, therapeutic, and laboratory results.

3. Evaluations and consultations.

4. Treatment objectives.

5. Discussion of risks and benefits.

6. Treatments.

7. Medications, including date, type, dosage, and quantity prescribed.

8. Instructions and agreements.

9. Periodic reviews.

10. Results of any drug testing.

11. A photocopy of the patient's government-issued photo identification.

12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant's ~~physician's~~ full name presented in a legible manner.

(g) A registrant shall immediately refer patients with signs or symptoms of substance abuse ~~shall be immediately referred~~ to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant's report, a prescribing registrant ~~physician~~ shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant's written report, the prescribing registrant ~~physician~~ shall incorporate the consultant's recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant ~~physician~~ shall be documented in

the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant ~~physician~~ who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

Section 9. Paragraph (b) of subsection (2) of section 458.3265, Florida Statutes, is amended to read:

458.3265 Pain-management clinics.—

(2) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(b) Only ~~a person may not dispense any medication on the~~

~~premises of a registered pain-management clinic unless he or she is~~ a physician licensed under this chapter or chapter 459 may dispense medication or prescribe a controlled substance regulated under chapter 893 on the premises of a registered pain-management clinic.

Section 10. Paragraph (b) of subsection (2) of section 459.0137, Florida Statutes, is amended to read:

459.0137 Pain-management clinics.—

(2) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any osteopathic physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(b) Only ~~a person may not dispense any medication on the premises of a registered pain-management clinic unless he or she is~~ a physician licensed under this chapter or chapter 458 may dispense medication or prescribe a controlled substance regulated under chapter 893 on the premises of a registered pain-management clinic.

Section 11. Paragraph (e) of subsection (4) of section 458.347, Florida Statutes, is amended, and paragraph (c) of subsection (9) of that section is republished, to read:

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(e) A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physician's practice unless such medication is listed on the formulary created pursuant to paragraph (f). A fully licensed physician assistant may only prescribe or dispense such medication under

the following circumstances:

1. A physician assistant must clearly identify to the patient that he or she is a physician assistant. Furthermore, the physician assistant must inform the patient that the patient has the right to see the physician prior to any prescription being prescribed or dispensed by the physician assistant.

2. The supervisory physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and notify the department of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. The physician assistant must file with the department a signed affidavit that he or she has completed a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal application. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the foregoing requirements. The physician assistant shall not

be required to independently register pursuant to s. 465.0276.

5. The prescription must be written in a form that complies with chapter 499 and must contain, in addition to the supervisory physician's name, address, and telephone number, the physician assistant's prescriber number. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465 and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. The appearance of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

(9) COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on Physician Assistants is created within the department.

(c) The council shall:

1. Recommend to the department the licensure of physician assistants.

2. Develop all rules regulating the use of physician assistants by physicians under this chapter and chapter 459, except for rules relating to the formulary developed under paragraph (4)(f). The council shall also develop rules to ensure that the continuity of supervision is maintained in each practice setting. The boards shall consider adopting a proposed rule developed by the council at the regularly scheduled meeting immediately following the submission of the proposed rule by the council. A proposed rule submitted by the council may not be adopted by either board unless both boards have accepted and

approved the identical language contained in the proposed rule. The language of all proposed rules submitted by the council must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board rejects the council's proposed rule, that board must specify its objection to the council with particularity and include any recommendations it may have for the modification of the proposed rule.

3. Make recommendations to the boards regarding all matters relating to physician assistants.

4. Address concerns and problems of practicing physician assistants in order to improve safety in the clinical practices of licensed physician assistants.

Section 12. Effective January 1, 2017, paragraph (f) of subsection (4) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(f)1. The council shall establish a formulary of medicinal drugs that a fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include ~~controlled substances as defined in chapter 893,~~ general anesthetics~~,~~ and radiographic contrast materials, and must limit the prescription of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply. The formulary must also restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age.

2. In establishing the formulary, the council shall consult

with a pharmacist licensed under chapter 465, but not licensed under this chapter or chapter 459, who shall be selected by the State Surgeon General.

3. Only the council shall add to, delete from, or modify the formulary. Any person who requests an addition, a deletion, or a modification of a medicinal drug listed on such formulary has the burden of proof to show cause why such addition, deletion, or modification should be made.

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each fully licensed physician assistant having prescribing authority under this section or s. 459.022, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund the provisions of this paragraph and paragraph (e).

Section 13. Subsection (2) of section 464.003, Florida Statutes, is amended to read:

464.003 Definitions.—As used in this part, the term:

(2) "Advanced or specialized nursing practice" means, in addition to the practice of professional nursing, the performance of advanced-level nursing acts approved by the board which, by virtue of postbasic specialized education, training, and experience, are appropriately performed by an advanced registered nurse practitioner. Within the context of advanced or specialized nursing practice, the advanced registered nurse

practitioner may perform acts of nursing diagnosis and nursing treatment of alterations of the health status. The advanced registered nurse practitioner may also perform acts of medical diagnosis and treatment, prescription, and operation as authorized within the framework of an established supervisory protocol ~~which are identified and approved by a joint committee composed of three members appointed by the Board of Nursing, two of whom must be advanced registered nurse practitioners; three members appointed by the Board of Medicine, two of whom must have had work experience with advanced registered nurse practitioners; and the State Surgeon General or the State Surgeon General's designee~~. ~~Each committee member appointed by a board shall be appointed to a term of 4 years unless a shorter term is required to establish or maintain staggered terms. The Board of Nursing shall adopt rules authorizing the performance of any such acts approved by the joint committee. Unless otherwise specified by the joint committee, such acts must be performed under the general supervision of a practitioner licensed under chapter 458, chapter 459, or chapter 466 within the framework of standing protocols which identify the medical acts to be performed and the conditions for their performance.~~ The department may, by rule, require that a copy of the protocol be filed with the department along with the notice required by s. 458.348.

Section 14. Section 464.012, Florida Statutes, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees; controlled substance prescribing.—

(1) Any nurse desiring to be certified as an advanced

registered nurse practitioner shall apply to the department and submit proof that he or she holds a current license to practice professional nursing and that he or she meets one or more of the following requirements as determined by the board:

(a) Satisfactory completion of a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.

(b) Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist or nurse midwife. The board may by rule provide for provisional state certification of graduate nurse anesthetists and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(c) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master's degree program shall be required for initial certification as a nurse practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master's degree program shall be required for initial certification as a registered nurse anesthetist under paragraph (4)(a).

(2) The board shall provide by rule the appropriate requirements for advanced registered nurse practitioners in the categories of certified registered nurse anesthetist, certified nurse midwife, and nurse practitioner.

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(a) Monitor and alter drug therapies.

(b) Initiate appropriate therapies for certain conditions.

(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(2).

(d) Order diagnostic tests and physical and occupational therapy.

(4) In addition to the general functions specified in subsection (3), an advanced registered nurse practitioner may perform the following acts within his or her specialty:

(a) The certified registered nurse anesthetist may, to the extent authorized by established protocol approved by the medical staff of the facility in which the anesthetic service is performed, perform any or all of the following:

1. Determine the health status of the patient as it relates to the risk factors and to the anesthetic management of the

patient through the performance of the general functions.

2. Based on history, physical assessment, and supplemental laboratory results, determine, with the consent of the responsible physician, the appropriate type of anesthesia within the framework of the protocol.

3. Order under the protocol preanesthetic medication.

4. Perform under the protocol procedures commonly used to render the patient insensible to pain during the performance of surgical, obstetrical, therapeutic, or diagnostic clinical procedures. These procedures include ordering and administering regional, spinal, and general anesthesia; inhalation agents and techniques; intravenous agents and techniques; and techniques of hypnosis.

5. Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.

6. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

7. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

8. Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.

9. Participate in management of the patient while in the postanesthesia recovery area, including ordering the administration of fluids and drugs.

10. Place special peripheral and central venous and

arterial lines for blood sampling and monitoring as appropriate.

(b) The certified nurse midwife may, to the extent authorized by an established protocol which has been approved by the medical staff of the health care facility in which the midwifery services are performed, or approved by the nurse midwife's physician backup when the delivery is performed in a patient's home, perform any or all of the following:

1. Perform superficial minor surgical procedures.

2. Manage the patient during labor and delivery to include amniotomy, episiotomy, and repair.

3. Order, initiate, and perform appropriate anesthetic procedures.

4. Perform postpartum examination.

5. Order appropriate medications.

6. Provide family-planning services and well-woman care.

7. Manage the medical care of the normal obstetrical patient and the initial care of a newborn patient.

(c) The nurse practitioner may perform any or all of the following acts within the framework of established protocol:

1. Manage selected medical problems.

2. Order physical and occupational therapy.

3. Initiate, monitor, or alter therapies for certain uncomplicated acute illnesses.

4. Monitor and manage patients with stable chronic diseases.

5. Establish behavioral problems and diagnosis and make treatment recommendations.

(5) The board shall certify, and the department shall issue a certificate to, any nurse meeting the qualifications in this

section. The board shall establish an application fee not to exceed $100 and a biennial renewal fee not to exceed $50. The board is authorized to adopt such other rules as are necessary to implement the provisions of this section.

(6)(a) The board shall establish a committee to recommend a formulary of controlled substances that an advanced registered nurse practitioner may not prescribe or may prescribe only for specific uses or in limited quantities. The committee must consist of three advanced registered nurse practitioners licensed under this section, recommended by the board; three physicians licensed under chapter 458 or chapter 459 who have work experience with advanced registered nurse practitioners, recommended by the Board of Medicine; and a pharmacist licensed under chapter 465 who is a doctor of pharmacy, recommended by the Board of Pharmacy. The committee may recommend an evidence-based formulary applicable to all advanced registered nurse practitioners which is limited by specialty certification, is limited to approved uses of controlled substances, or is subject to other similar restrictions the committee finds are necessary to protect the health, safety, and welfare of the public. The formulary must restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age to advanced registered nurse practitioners who also are psychiatric nurses as defined in s. 394.455. The formulary must also limit the prescribing of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply, except that such restriction does not apply to controlled substances that are psychiatric medications prescribed by psychiatric nurses as defined in s. 394.455.

(b) The board shall adopt by rule the recommended formulary and any revision to the formulary which it finds is supported by evidence-based clinical findings presented by the Board of Medicine, the Board of Osteopathic Medicine, or the Board of Dentistry.

(c) The formulary required under this subsection does not apply to a controlled substance that is dispensed for administration pursuant to an order, including an order for medication authorized by subparagraph (4)(a)3., subparagraph (4)(a)4., or subparagraph (4)(a)9.

(d) The board shall adopt the committee's initial recommendation no later than October 31, 2016.

Section 15. Effective January 1, 2017, subsection (3) of section 464.012, Florida Statutes, as amended by this act, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees; controlled substance prescribing.—

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the

established framework, an advanced registered nurse practitioner may:

(a) Prescribe, dispense, administer, or order any drug; however, an advanced registered nurse practitioner may prescribe or dispense a controlled substance as defined in s. 893.03 only if the advanced registered nurse practitioner has graduated from a program leading to a master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills ~~Monitor and alter drug therapies~~.

(b) Initiate appropriate therapies for certain conditions.

(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(2).

(d) Order diagnostic tests and physical and occupational therapy.

Section 16. Subsection (3) of section 464.013, Florida Statutes, is amended to read:

464.013 Renewal of license or certificate.—

(3) The board shall by rule prescribe up to 30 hours of continuing education biennially as a condition for renewal of a license or certificate.

(a) A nurse who is certified by a health care specialty program accredited by the National Commission for Certifying Agencies or the Accreditation Board for Specialty Nursing Certification is exempt from continuing education requirements. The criteria for programs must ~~shall~~ be approved by the board.

(b) Notwithstanding the exemption in paragraph (a), as part of the maximum 30 hours of continuing education hours required under this subsection, advanced registered nurse practitioners certified under s. 464.012 must complete at least 3 hours of

continuing education on the safe and effective prescription of controlled substances. Such continuing education courses must be offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit, the American Nurses Credentialing Center, the American Association of Nurse Anesthetists, or the American Association of Nurse Practitioners and may be offered in a distance learning format.

Section 17. Paragraph (p) is added to subsection (1) of section 464.018, Florida Statutes, and subsection (2) of that section is republished, to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(p) For an advanced registered nurse practitioner:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing on Schedule II in chapter 893.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine, a sympathomimetic amine drug, or a compound designated in s. 893.03(2) as a Schedule II controlled substance, to or for any person except for:

a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term "muscle building" does not include the treatment of injured muscle. A prescription written for the drug products identified in this subparagraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: "This prescription may be filled at any pharmacy of your choice."

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced registered nurse practitioner's professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the advanced registered nurse practitioner by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a substance designated in s. 893.03(2) or (3) as a substance controlled in Schedule II or Schedule III, respectively, in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a substance designated in s. 893.03 as a controlled substance.

(2) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

Section 18. Section 627.42392, Florida Statutes, is created to read:

627.42392 Prior authorization.—

(1) As used in this section, the term "health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a managed care plan as defined in s. 409.901(13), or a health maintenance organization as defined in s. 641.19(12).

(2) Notwithstanding any other provision of law, in order to

establish uniformity in the submission of prior authorization forms on or after January 1, 2017, a health insurer, or a pharmacy benefits manager on behalf of the health insurer, which does not use an electronic prior authorization form for its contracted providers shall use only the prior authorization form that has been approved by the Financial Services Commission to obtain a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation.

(3) The Financial Services Commission shall adopt by rule guidelines for all prior authorization forms which ensure the general uniformity of such forms.

Section 19. Subsection (11) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.—

(11) A health insurer may not retroactively deny a claim because of insured ineligibility:

(a) At any time, if the health insurer verified the eligibility of an insured at the time of treatment and provided an authorization number.

(b) More than 1 year after the date of payment of the claim.

Section 20. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility:

(a) At any time, if the health maintenance organization

verified the eligibility of an insured at the time of treatment and provided an authorization number.

(b) More than 1 year after the date of payment of the claim.

Section 21. Subsection (21) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(21) "Practitioner" means a physician licensed under ~~pursuant to~~ chapter 458, a dentist licensed under ~~pursuant to~~ chapter 466, a veterinarian licensed under ~~pursuant to~~ chapter 474, an osteopathic physician licensed under ~~pursuant to~~ chapter 459, an advanced registered nurse practitioner certified under chapter 464, a naturopath licensed under ~~pursuant to~~ chapter 462, a certified optometrist licensed under ~~pursuant to~~ chapter 463, ~~or~~ a podiatric physician licensed under ~~pursuant to~~ chapter 461, or a physician assistant licensed under chapter 458 or chapter 459, provided such practitioner holds a valid federal controlled substance registry number.

Section 22. Paragraph (n) of subsection (1) of section 948.03, Florida Statutes, is amended to read:

948.03 Terms and conditions of probation.—

(1) The court shall determine the terms and conditions of probation. Conditions specified in this section do not require oral pronouncement at the time of sentencing and may be considered standard conditions of probation. These conditions may include among them the following, that the probationer or offender in community control shall:

(n) Be prohibited from using intoxicants to excess or possessing any drugs or narcotics unless prescribed by a physician, an advanced registered nurse practitioner, or a physician assistant. The probationer or community controllee may ~~shall~~ not knowingly visit places where intoxicants, drugs, or other dangerous substances are unlawfully sold, dispensed, or used.

Section 23. Paragraph (a) of subsection (1) and subsection (2) of section 458.348, Florida Statutes, are amended to read:

458.348 Formal supervisory relationships, standing orders, and established protocols; notice; standards.—

(1) NOTICE.—

(a) When a physician enters into a formal supervisory relationship or standing orders with an emergency medical technician or paramedic licensed pursuant to s. 401.27, which relationship or orders contemplate the performance of medical acts, or when a physician enters into an established protocol with an advanced registered nurse practitioner, which protocol contemplates the performance of medical ~~acts identified and approved by the joint committee pursuant to s. 464.003(2) or~~ acts set forth in s. 464.012(3) and (4), the physician shall submit notice to the board. The notice shall contain a statement in substantially the following form:

I, ...(name and professional license number of physician)..., of ...(address of physician)... have hereby entered into a formal supervisory relationship, standing orders, or an established protocol with ...(number of persons)... emergency medical technician(s), ...(number of persons)...

paramedic(s), or ...(number of persons)... advanced registered nurse practitioner(s).

(2) ESTABLISHMENT OF STANDARDS BY JOINT COMMITTEE.—The joint committee ~~created under s. 464.003(2)~~ shall determine minimum standards for the content of established protocols pursuant to which an advanced registered nurse practitioner may perform medical acts ~~identified and approved by the joint committee pursuant to s. 464.003(2)~~ or acts set forth in s. 464.012(3) and (4) and shall determine minimum standards for supervision of such acts by the physician, unless the joint committee determines that any act set forth in s. 464.012(3) or (4) is not a medical act. Such standards shall be based on risk to the patient and acceptable standards of medical care and shall take into account the special problems of medically underserved areas. The standards developed by the joint committee shall be adopted as rules by the Board of Nursing and the Board of Medicine for purposes of carrying out their responsibilities pursuant to part I of chapter 464 and this chapter, respectively, but neither board shall have disciplinary powers over the licensees of the other board.

Section 24. Paragraph (a) of subsection (1) of section 459.025, Florida Statutes, is amended to read:

459.025 Formal supervisory relationships, standing orders, and established protocols; notice; standards.—

(1) NOTICE.—

(a) When an osteopathic physician enters into a formal supervisory relationship or standing orders with an emergency medical technician or paramedic licensed pursuant to s. 401.27,

which relationship or orders contemplate the performance of medical acts, or when an osteopathic physician enters into an established protocol with an advanced registered nurse practitioner, which protocol contemplates the performance of medical acts ~~identified and approved by the joint committee pursuant to s. 464.003(2)~~ or acts set forth in s. 464.012(3) and (4), the osteopathic physician shall submit notice to the board. The notice must contain a statement in substantially the following form:

I, ...(name and professional license number of osteopathic physician)..., of ...(address of osteopathic physician)... have hereby entered into a formal supervisory relationship, standing orders, or an established protocol with ...(number of persons)... emergency medical technician(s), ...(number of persons)... paramedic(s), or ...(number of persons)... advanced registered nurse practitioner(s).

Section 25. Subsection (10) of s. 458.331, paragraph (g) of subsection (7) of s. 458.347, subsection (10) of s. 459.015, paragraph (f) of subsection (7) of s. 459.022, and paragraph (b) of subsection (5) of s. 465.0158, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 456.072, Florida Statutes, in references thereto.

Section 26. Paragraph (mm) of subsection (1) of s. 456.072 and s. 466.02751, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 456.44, Florida Statutes, in references thereto.

Section 27. Section 458.303, paragraph (b) of subsection (7) of s. 458.3475, paragraph (e) of subsection (4) and

paragraph (c) of subsection (9) of s. 459.022, and paragraph (b) of subsection (7) of s. 459.023, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 458.347, Florida Statutes, in references thereto.

Section 28. Paragraph (c) of subsection (3) of s. 464.012, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 464.003, Florida Statutes, in a reference thereto.

Section 29. Paragraph (a) of subsection (1) of s. 456.041, subsections (1) and (2) of s. 458.348, and subsection (1) of s. 459.025, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 464.012, Florida Statutes, in references thereto.

Section 30. Subsection (7) of s. 464.0205, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 464.013, Florida Statutes, in a reference thereto.

Section 31. Subsection (11) of s. 320.0848, subsection (2) of s. 464.008, subsection (5) of s. 464.009, and paragraph (b) of subsection (1), subsection (3), and paragraph (b) of subsection (4) of s. 464.0205, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 464.018, Florida Statutes, in references thereto.

Section 32. Section 775.051, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 893.02, Florida Statutes, in a reference thereto.

Section 33. Paragraph (a) of subsection (3) of s. 944.17, subsection (8) of s. 948.001, and paragraph (e) of subsection (1) of s. 948.101, Florida Statutes, are reenacted for the

purpose of incorporating the amendment made by this act to s. 948.03, Florida Statutes, in references thereto.

Section 34. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 12, 2016

I respectfully request that **Senate Bill #676**, relating to Access to Health Care Services, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

676
Bill Number (if applicable)

Topic Access to Health care services

Amendment Barcode (if applicable)

Name Corinne Mixon

Job Title Lobbyist

Address 119 E. Park Ave
Street

Phone 7665745

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Florida Academy of Physician Assistants

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

676
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Lyon

Job Title Attorney

Address 315 S. Calhoun St., Ste. 830
Street

Tall FL 32301
City *State* *Zip*

Phone 222-5702

Email clyon@flw-law.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Association of Nurse Anesthetists

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

6716
Bill Number (if applicable)

Topic Access to Health care services

Amendment Barcode (if applicable)

Name Mary Thomas

Job Title ~~Assistant General~~ Counsel

Address 1430 Piedmont Dr E
Street

Phone 850 224 6496

TLH FL 32308
City *State* *Zip*

Email MThomas@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

676
Bill Number (if applicable)

Topic Healthcare/ARNP+PA Prescribing

Amendment Barcode (if applicable)

Name Melody Arnold

Job Title Govt Affairs Mngr

Address 307 West Park Ave
Street

Phone (850)224-3907

TLH FL 32301
City *State* *Zip*

Email marnold@fhca.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Health Care Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

SB 676
Bill Number (if applicable)

Topic Health Care

Amendment Barcode (if applicable)

Name Zayne Smith

Job Title ASD

Address 200 W. College Ave
Street

Phone 850 228-4243

Tally FL 32301
City *State* *Zip*

Email Zsmith@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

9:00AM
Room 110 SOB

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-2016
Meeting Date

SB 676
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic HEALTH CARE

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DR
Street

Phone 878-7364

TALLAHASSEE, FL 32308
City *State* *Zip*

Email

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

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

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-16
Meeting Date

676
Bill Number (if applicable)

Topic APRN & PA Prescribing of Controlled Substances

Amendment Barcode (if applicable)

Name Martha DeCastro

Job Title VP for Nursing

Address 306 E. College Ave
Street

Tallahassee FL 32301
City *State* *Zip*

Phone (850) 222 9188

Email martha@fha.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Hospital Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

676
Bill Number (if applicable)

Topic Prescribing by ARNPs + PAs

Amendment Barcode (if applicable)

Name Elizabeth Gwinn

Job Title VP Patient Care

Address 14500 Old St. Augustine Rd
Street

Jacksonville FL 32258
City *State* *Zip*

Phone 904-271-6003

Email elizabeth.gwinn@bmcjax.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Baptist Health, Jacksonville

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

676
Bill Number (if applicable)

Topic Prescribing Controlled Substances

Amendment Barcode (if applicable)

Name Barbara Lumpkin

Job Title Consultant

Address 468 Green Spring Cir
Street

Phone 407 227 7705

Winter Springs FL 32708
City *State* *Zip*

Email

Wave

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Baptist Health South Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-16
Meeting Date

SB 676
Bill Number (if applicable)

Topic ARNP Prescribing

Amendment Barcode (if applicable)

Name Allison Carvajal

Job Title Lobbyist

Address 120 S. Monroe
Street

Phone 727-7041

TLH *City* FL *State* 32312 *Zip*

Email allison@carvajal-tally.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Nurse Practitioner Network

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/15
Meeting Date

676
Bill Number (if applicable)

Topic Nurse Practitioner Prescribing

Amendment Barcode (if applicable)

Name Alisa LaPolt

Job Title Lobbyist

Address _____
Street

Phone 443-1319

Tallahassee
City *State* *Zip*

Email _____

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

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

Representing Florida Nurses Association

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

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-16
Meeting Date

SB 676
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Paul Sanford

Job Title _____

Address 106 S. Monroe ST
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 222-7200

Email _____

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Florida Blue [redacted]

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-2016
Meeting Date

SB676
Bill Number (if applicable)

Topic Health Care

Amendment Barcode (if applicable)

Name Joy Ryan

Job Title

Address 325 W. College
Street

Phone 425-4006

32312
City *State* *Zip*

Email joyryan911@comcast.net

Speaking: ☐ For ☒ Against ☐ Information

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

Representing AHIP, Prime Therapeutics

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

1/26/14 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB 674

Meeting Date *Bill Number (if applicable)*

Topic Controlled Substance Prescribing by ARNP + PA *Amendment Barcode (if applicable)*

Name Susan Salahshor

Job Title Director Florida Academy of PAs

Address 175 Queen Victoria Ave Phone 9047109078

Street

Jacksonville FL 32259 Email pasuecares@comcast.net

City *State* *Zip*

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

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

Representing Florida Academy of PAs

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

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 986
INTRODUCER:	Senator Simpson
SUBJECT:	Workers' Compensation System Administration
DATE:	January 25, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			AGG	
3.			AP	

I. Summary:

SB 986 amends provisions of ch. 440, F.S., the "Workers Compensation Law," which is administered by the Department of Financial Services (DFS).

The bill changes workers compensation coverage requirements as follows:

- Allows non-construction industry limited liability company (LLC) members to "opt-in" to the workers' compensation system; current law instead allows them to "opt-out."
- Allows employers to notify their insurers of their employee's coverage exemption, rather than requiring that a copy of the exemption be provided.
- No longer requires construction employers to maintain written exemption acknowledgements.
- Deletes a requirement that exemption revocations be filed by mail only.

The bill affects provisions related to compliance and enforcement as follows:

- Creating a 25 percent penalty credit for employers who have not been previously issued a stop-work order or order of penalty assessment for non-compliance with coverage requirements if they maintain required business records and timely respond to the written DFS business records requests.
- Establishing a deadline for employers to file certain documentation to receive a penalty reduction.
- Reducing the imputed payroll multiplier related to penalty calculations from 2 times to 1.5 times the statewide average weekly wage.
- Eliminating a 3-day response requirement applicable to employer held exemption documentation.

The bill eliminates fees collected by the DFS relating to new insurer registration and Special Disability Trust Fund notices of claim and proofs of claim.

The bill revises provisions related to Health Care Services and Disputes as follows:

- Removes insurers and employers from the medical reimbursement dispute provision since they meet their adjustment, disallowance and provider violation reporting duties through other provisions of law.
- Allows a Judge of Compensation Claims to designate an expert medical examiner of their choosing, rather than only those that are certified by the DFS.

The bill also:

- Eliminates the requirement for employers to notify the DFS by telephone or telegraph within 24 hours of any work related death and instead uses other existing reporting requirements.
- Eliminates the Preferred Worker Program, which has been inactive for over 10 years.

The effective date of the bill is October 1, 2016.

II. Present Situation:

Administration of the Workers' Compensation System in Florida

The Division of Workers' Compensation within the Department of Financial Services is responsible for administering ch. 440, F.S., which includes the enforcement of coverage requirements,[1] administration of workers' compensation health care delivery system,[2] data collection,[3] and assist injured workers, employers, insurers, and providers in fulfilling their responsibilities under ch. 440, F.S.[4]

Coverage Requirements

Whether an employer is required to have workers' compensation insurance depends upon the employer's industry and the number of employees. Employers may secure coverage by purchasing a workers' compensation insurance policy or qualifying as a self-insurer.[5]

Limited Liability Companies Coverage Requirements

For purposes of workers' compensation coverage requirements, a member of a limited liability company (LLC),[6] is an employee if the member owns 10 percent of the company. As an employee, the LLC member must be covered whenever workers' compensation is required to be provided by the LLC. If the LLC is engaged in the construction industry, coverage must always

[1] Section 440.107(3), F.S.
[2] Section 440.13, F.S.
[3] Section 440.185 and 440.593, F.S.
[4] Section 440.191, F.S.
[5] Section 440.38, F.S.
[6] Limited liability companies are organized under ch. 605, F.S. A limited liability company is a hybrid business entity having characteristics of both a corporation and a partnership. It is similar to a corporation because it provides its owners with limited liability for the actions and debt of the company, but it is taxed more like a partnership. A limited liability company does not have stockholders. It is composed of members. The members are the owners of the company and are usually considered the equivalent of stockholders. See http://www.sunbiz.org/faqcor.html (last visited Jan. 23, 2016).

be provided, and if the LLC is not engaged in the construction industry,[7] the LLC must obtain coverage if there are four or more "employees."

An LLC member may elect to be exempt or opt out from workers' compensation coverage requirement upon application to and approval by the DFS.[8] Individuals who elect an exemption are not considered "employees," for premium calculation purposes, and are not eligible to receive workers' compensation benefits if they suffer a workplace injury.

The DFS reports that the number of non-construction exemption applications processed by them more than tripled from fiscal year 2010-2011 to fiscal year 2014-2015.[9] The DFS attributes this increase to the availability of exemptions to non-construction LLC members.[10] For calendar years 2010-2015, the Department of State reported a significant increase in the number of domestic LLCs filings -- from 145,780 to 214,724.[11]

Enforcement of Coverage Requirements

Stop Work Orders

If an employer fails to comply with workers' compensation coverage requirements, the DFS must issue a stop-work order (SWO) within 72 hours of determining noncompliance.[12] The SWO requires the employer to cease all business operations. The SWO remains in effect until the employer secures appropriate coverage and the DFS issues an order releasing the SWO (for employers that have paid the assessed penalty); or an order of conditional release (for employers that have agreed to pay the penalty in installments pursuant to a payment agreement schedule with the DFS).

An SWO is issued for the following violations:

- Failure to obtain workers' compensation insurance;
- Material understatement or concealment of payroll;
- Material misrepresentation or concealment of employee duties to avoid paying the proper premium;
- Material concealment of information pertinent to the calculation of an experience modification factor; and

[7] However, if the LLC is an agricultural employer, the workers' compensation coverage requirement applies if there are six or more regular employees and/or 12 or more seasonal employees who work for more than 30 days. s. 440.02(17)(c)2., F.S.
[8] Section 440.02(9) and (15)(b)1., F.S. LLC members with 10 percent or more ownership of the LLC are defined as "corporate officers" for purposes of workers' compensation coverage. "Corporate officers" are permitted to elect a coverage exemption.
[9] In fiscal year 2010-2011, the DFS processed 11,448 non-construction exemption applications. This increased to 36,496 applications processed in fiscal year 2014-2015. Email from the Division of Workers' Compensation, Department of Financial Services, (Jan. 5, 2016) (on file with Senate Committee on Banking and Insurance).
[10] Florida Department of Financial Services, *Division of Workers' Compensation 2015 Results & Accomplishments Report*, at 6, *available at* http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Reports/AnnualReportWC2015.pdf. (last visited Jan. 23, 2016).
[11] Department of State, Division of Corporations, *Yearly Statistics*, at http://sunbiz.org/corp_stat.html (last visited Jan. 23, 2016)
[12] Section 440.107, F.S.

- Failure to produce business records within 10 days of receipt of a written request from the DFS.[13]

Imposition of Payroll for Penalty Purposes

In addition to the SWO, employers are assessed a penalty equal to 2.0 times what the employer would have paid in workers' compensation premiums for all periods of non-compliance during the preceding 2-year period or $1,000, whichever is greater.[14] The SWO remains in effect and the employer cannot conduct business until the DFS has calculated the penalty imputed based on payroll. Sometimes, an employer will not have the required payroll information or will not comply with the DFS' business records request. Section 440.107(7), F.S., provides a means for the DFS to impute the employer's payroll for penalty purposes.

The imputed payroll under the law is twice the statewide average weekly wage (SAWW)[15] for each individual that the employer failed to cover. Depending on the circumstances of a particular case, the DFS may have to impute payroll for all of the employees for the entire two-year period or the DFS may only have to impute payroll for a one or more employees for a small portion of the two-year period. It depends upon the quality and availability of the employer's records. When the DFS authority to impute payroll was added to the law in 2003,[16] as one of the deterrents to fight fraud, it was set at 1.5 times the SAWW. It was increased to 2 times the SAWW in 2014. The DFS suggests that this can lead to "exorbitant penalty amounts that do not correlate with the violation committed by the employer."[17]

Avoiding Work Stoppage and Minimizing Penalties Due to Noncompliance

There are a two ways for a non-compliant employer to mitigate the impact of a DFS finding of non-compliance on their business operations. First, if the employer comes into compliance after initiation of an investigation, but before they are ordered to stop work, an SWO is not issued. Instead, if the law requires penalties, the DFS will only levy penalties. In that case, the penalties are levied an Order of Penalty Assessment (OPA). This permits the employer to avoid work stoppage due to an SWO, while also achieving compliance. This also provides the employer an opportunity to reduce their potential penalty. If the employer has never received an SWO before, the employer may receive a credit against the penalty equal to the amount of the initial payment of workers' compensation premium resulting from them achieving compliance following the initiation of the DFS investigation.[18]

DFS Compliance and Enforcement Statistics FY 2014-2015

For fiscal year 2014-2015, the DFS issued 2,727 SWOs with approximately $52.4 million in penalties to employers that violated the coverage requirements.[19] The DFS imputed payroll

[13] Section 440.107(7)(d), F.S.
[14] Section 440.107(7)(d), F.S.
[15] The statewide average weekly wage is determined by the DFS pursuant to s. 440.12(2), F.S.
[16] Ch. 2003-412, s. 13, Laws of Fla.
[17] Email from the Division of Workers' Compensation, Department of Financial Services, (Jan. 6, 2016) (on file with the Senate Committee on Banking and Insurance).
[18] Section 440.107(7)(d)1., F.S.
[19] Florida Department of Financial Services, *Division of Workers' Compensation 2015 Results & Accomplishments Report*, at http://www.myfloridacfo.com/Division/WC/PublicationsFormsManualsReports/Reports/AnnualReportWC2015.pdf.

against the employer in 1,584 cases.[20] The DFS issued 256 OPAs levying about $3.1 million in penalties when an employer came into compliance with the coverage requirements prior to the issuance of an SWO. The DFS reports that they are able to collect between 25 percent and 35 percent of the penalties they assess.[21]

The DFS maintains an online database of exemption holders.[22] The DFS reports that of the 367 non-construction LLCs that received an SWO in fiscal year 2014-2015, 32 corrected their non-compliance because one or more LLC members obtained exemptions.[23] An additional 30 non-construction LLCs achieved compliance by purchasing coverage for four employees. Some portion of these may be related to non-exempt LLC members falling within the definition of "employee," which would result in an SWO.

Medical Reimbursement Disputes

The DFS is responsible for resolving medical reimbursement disputes between health care providers and insurers[24] or employers.[25] Health care providers, insurers, and employers have 45 days from receipt of notice of disallowance or adjustment of payment from an insurer to file a reimbursement dispute petition with the DFS. Insurers have 30 days from receipt of the provider's petition to submit all documentation substantiating the insurer's disallowance or adjustment to the DFS; otherwise they waive all objections to the petition. The DFS has 120 days from receipt of all documentation to issue a written determination. The DFS's determination is subject to the hearing provisions of the Administrative Procedures Act.[26]

Insurers are required to report all instances of health care provider overutilization to the DFS.[27] The DFS has implemented rules formalizing the procedure for reporting alleged provider violations.[28] Any interested person can report an alleged provider violation through this procedure. Additionally, the DFS collects adjustment information for all reported workers' compensation medical bills. When the insurer properly codes and reports their adjustments and reimbursement decisions, the DFS can use their electronic database to identify alleged overutilization. Insurer compliance with electronic bill reporting requirements satisfies their statutory obligation to report all instances of overutilization.[29] The inclusion of insurers and

[20] Department of Financial Services, Analysis of Senate Bill 986, (Jan. 6, 2016) (on file with Senate Committee on Banking and Insurance).
[21] Department of Financial Services, Analysis of Senate Bill 986, (Jan. 6, 2016) (on file with Senate Committee on Banking and Insurance).
[22] *Division of Workers' Compensation Proof of Coverage Search Page*, https://apps8.fldfs.com/proofofcoverage/Search.aspx (last visited Jan. 4, 2016). Filter search by "Exemption Holder Name" or "Exemption Holder SSN."
[23] Email from the Division of Workers' Compensation, Department of Financial Services, (Jan. 5, 2016) (on file with Senate Banking and Insurance Committee).
[24] The terms "carrier" and "insurer" are commonly used interchangeably within the context of the workers' compensation law. In fact, the definition of "insurer" expressly includes the term "carrier." s. 440.02(38), F.S. "Carrier" means any person or fund authorized under s. 440.38 to insure under this chapter and includes a self-insurer, and a commercial self-insurance fund authorized under s. 624.462. s. 440.02(4), F.S. While this analysis uses the term "insurer" in this instance to maintain internal consistency, the portion of the bill described strikes the term "carrier" from statute.
[25] Section 440.13(7), F.S.
[26] Ch. 120, F.S.
[27] s. 440.13(6), F.S.
[28] Chapter 69L-34, F.A.C.
[29] Rule 69L-34.002, F.A.C.

employers in the medical reimbursement dispute provision can lead to confusion over the correct method for insurer or employer reporting of alleged provider violations and insurer reporting of medical overutilization issues.

Expert Medical Advisors and Judges of Compensation Claims

The Office of the Judges of Compensation Claims is responsible for resolving workers' compensation benefit disputes.[30] A Judge of Compensation Claims (JCC) receives medical evidence and testimony in the course of administering their assigned cases. Whenever there is a conflict in medical evidence or medical opinion, the JCC must appoint an Expert Medical Advisor (EMA) to address the conflict.[31] EMAs are certified by the DFS.[32]

Certification as an EMA requires specialized workers' compensation training or experience and medical board certification or eligibility. The DFS is also required to "consider the qualifications, training, impartiality, and commitment of the health care provider to the provision of quality medical care at a reasonable cost."[33] Currently, there are 153 EMAs certified by the DFS.[34] The procedures that an EMA must abide by and the party responsible for the cost of the EMA's services are established by statute.[35]

The JCCs often have difficulty finding an eligible EMA to assist them with a case. This often occurs because there are too few EMAs in a particular specialty or the EMAs present in the local area of the injured worker have a conflict in participating in the matter because they have previously treated the injured worker or consulted in their care. When this occurs, the JCC identifies a willing provider with the appropriate qualifications and submits their information to the DFS for certification. Since the JCC has already considered the prospective EMA's qualifications, there is little benefit in going through the additional burden and delay of submitting the prospective EMA to the DFS for certification.

Workers' Compensation Special Disability Trust Fund

The Florida Special Disability Trust Fund (SDTF) was established to encourage the employment of workers with preexisting permanent physical impairments. The SDTF reimburses employers (or their carriers) for the excess in workers' compensation benefits provided to an employee with a pre-existing impairment who is subsequently injured in a workers' compensation accident. As part of the reimbursement process, the SDTF determines whether claims are eligible to receive reimbursements, as well as audits and processes reimbursement requests. Reimbursement under the SDTF is not available for injuries occurring on or after January 1, 1998. The SDTF is funded by annual assessments on insurers providing compensation insurance coverage. Claims with an accident date before 1998 are still eligible to seek reimbursements. After a claim has been accepted, a request for reimbursement of additional expenses may be submitted annually.

[30] s. 440.192, F.S.
[31] s. 440.25(4)(d), F.S.
[32] s. 440.13(9)(a), F.S.
[33] Id.
[34] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Florida Division of Workers' Compensation Expert Medical Advisor List*, https://apps.fldfs.com/provider/ (last visited Jan. 5, 2016).
[35] Section 440.13(9), F.S.

Currently, every Notice of Claim against the SDTF must be submitted with a $250 fee. An insurer that files a notice of claim against the SDTF must submit certain documents to perfect their claim. If the required documents are not filed with their notice of claim, they must file a proof of claim and include a $500 fee.

Preferred Worker Program

The Preferred Worker Program (PWP) was enacted by the Legislature and became effective January 1, 1994.[36] The intent of the program was to provide financial incentives for employers to hire employees who suffered a workplace injury resulting in permanent physical disability and are unable to return to work for their previous employer. The PWP would reimburse an employer for the costs of workers' compensation insurance premium related to the preferred worker for up to 3 years of continuous employment. This reimbursement was to be paid from the SDTF.[37] The Department of Financial Services and the Department of Education have rulemaking authority to implement the program.

III. Effect of Proposed Changes:

Coverage Requirements

The bill removes non-construction industry LLC members that own 10 percent of the LLC from the definition of "employee." Accordingly, they are no longer subject to the coverage requirement or permitted to claim an exemption from coverage. Instead, the bill allows them, or any non-construction LLC member, regardless of ownership percentage, to "opt-in" to the workers' compensation system through an election of coverage[38] that they may file with the DFS.[39] (Sections 1 and 3)

The bill removes a requirement that exemption holders revoke their exemptions by mail. This will allow electronic revocations.[40] Since the DFS maintains an online exemption application and record review system, the DFS could add online revocation requests to their system. (Section 3)

The bill removes the requirement that exemption applicants provide their Federal Tax Identification Number when filing an electronic application for exemption with the DFS.[41] The Internal Revenue Service does not issue Federal Tax Identification Numbers to individuals; rather, they are issued to businesses. The Federal Tax Identification Number of the applicant's employer will still be collected. (Section 3)

[36] Ch.93-415, s. 43, Laws of Fla.
[37] s. 440.49(8), F.S.
[38] s. 440.02(15)(c)1., F.S.
[39] Despite an individual electing employee status, whether the employer is required to obtain workers' compensation coverage is still dependent upon whether the employer has the threshold number of employees. The threshold number is one employee for construction employers, four or more employees for non-construction employers, and six or more regular employees and/or 12 or more seasonal employees who work for more than 30 days for agricultural employers. s. 440.02(15)–(17), F.S.
[40] s. 440.05(1), (2), and (5), F.S. DFS reports that 2,314 exemption holders filed voluntary revocations in fiscal year 2014-2015. Email from the Division of Workers' Compensation, Department of Financial Services, (Jan. 6, 2016) (on file with Committee on Banking and Insurance).
[41] Section. 440.05(3), F.S.

The bill changes a requirement that employers provide their insurer with copies of their employee's certificate of exemption, instead the employer will notify the insurer of the exemptions.[42] Since the DFS maintains online exemption information, the insurer can still verify the exemption without needing a copy of the certificate of exemption. (Section 3)

The bill removes a requirement that construction employers maintain written exemption acknowledgements by their corporate officers that hold an exemption certificate.[43] The bill also eliminates the 3-day response requirement applicable to exemption information held by the employer since the DFS maintains these records online. (Section 3)

Compliance and Enforcement; Penalties

The bill reduces the imputed payroll multiplier from 2 times the statewide average weekly wage and returns it to the pre-2014 level of 1.5 times the statewide average weekly wage. (Section 4)

The bill adds two new eligibility requirements to the existing penalty credit for achieving compliance after the initiation of an investigation and adds a second penalty credit. The bill requires non-compliant employers to document their purchase of coverage to the DFS within 28 days of the Stop Work Order or Order of Penalty Assessment to qualify for the reduction in penalty and requires that the employer has never before received an SWO or OPA, rather than just an SWO. The bill creates another penalty credit for non-compliant employers who have never previously received an SWO or OPA. If they maintain business records consistent with the requirements of s. 440.107(5), F.S.,[44] and timely respond to the written DFS business records requests (a 10-day response requirement), the DFS must reduce their penalty by 25 percent. (Section 4)

Medical Services; Disputes

The bill removes insurers and employers from the provision allowing the filing of a medical reimbursement dispute over the disallowance or adjustment of a medical payment. Accordingly, only health care providers will be permitted to file petitions for resolution of medical billing disputes. (Section 5)

The bill allows a JCC to designate an EMA of their choosing, rather than only those that are certified as EMAs by the DFS. EMAs, whether certified by the DFS or designated by the JCC, will continue to be subject to the existing procedural requirements of statute. (Section 5)

Elimination of Fees

The bill eliminates the registration fee of $100 required to be paid by every new workers' compensation carrier that registers with the DFS.[45] (Section 10)

[42] Id.
[43] Section. 440.05(10), F.S.
[44] Section 440.107(5), F.S., requires the DFS to adopt rules specifying the business records that the employer must maintain. Rule 69L-6.015, F.A.C., contains these requirements.
[45] s. 440.52(1), F.S.

The bill eliminates the SDTF Notice of Claim Fee of $250 and the Proof of Claim Fee of $500 Special Disability Trust Fund. (Section 8)

Other Provisions

The bill removes a requirement that employers notify the DFS by telephone or telegraph within 24 hours of any work related death.[46] This relates to an obsolete function when the DFS had a role in workplace safety investigations. However, the DFS' former workplace safety role is preempted to the federal Occupational Safety and Health Administration of the Department of Labor with some exceptions.[47] The employers not covered[48] by the OSHA include self-employed workers, immediate family members of farm employers, and workers whose hazards are regulated by another federal agency (for example, the Mine Safety and Health Administration, the Department of Energy, or Coast Guard).[49] The DFS will continue to receive reports of death through an existing employer-reporting requirement.[50] (Section 6)

The bill eliminates the Preferred Worker Program. The program has experienced a small number of claims and has not made any program reimbursements in over a decade. The DFS reports that the program paid seven claims totaling $15,915 since 1994. The DFS last issued a reimbursement under the program in 2002.[51] (Section 8)

The bill provides technical, conforming changes to revises cross-references to conform to changes made by the bill. (Sections 2, 7, 9, and 11)

The bill is effective October 1, 2016. (Section 12)

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[46] s. 440.185(3), F.S.
[47] The OSHA requires employers subject to OSHA to report fatalities within 8 hours.https://www.osha.gov/as/opa/worker/employer-responsibility.html.
[48] https://www.osha.gov/OSHA_FAQs.html.
[49] Workers at state and local government agencies are not covered by Federal OSHA, but have the OSHA protections if they work in those states that have an OSHA-approved state program.
[50] s. 440.185(2), F.S.
[51] Florida Department of Financial Services, Agency Analysis of 2016 House Bill 613, p. 2 (Dec. 8, 2015).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill eliminates the new insurer registration fee of $100 and the SDTF Notice of Claim and Proof of Claim fees of $250 and $500, respectively.

B. Private Sector Impact:

The bill eliminates the new insurer registration fee of $100. The DFS reports that four registrations for new workers' compensation insurers were received in FY 2014-2015.

Insurers filing SDTF Notices of Claim or Proofs of Claim will no longer be assessed the $250 and $500 fee, respectively.

C. Government Sector Impact:

The bill eliminates the SDTF Notice of Claim fee of $250 and the SDTF Proof of Claim fee of $300. Insurers may continue to file notices of claim and proofs of claims. The SDTF received no notices of claims or proofs of claims in FY 2013-14 and one notice of claim in FY 2014-15. [52]

The bill eliminates the new insurer registration fee of $100. New insurers will continue to register with the DFS as a workers' compensation insurer, except without the fee. The DFS reports that four new registrations were received in fiscal year 2014-2015.[53]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The changes to s. 440.13, F.S., regarding certification of Expert Medical Advisors may create statutory ambiguity that could lead to various interpretations and perhaps litigation. Removing the DFS obligation for certification of EMA providers may result in the appointment of individuals without credentials and subject only to the Judge of Compensation's conclusion of qualifications or expertise.[54]

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[52] AMI Risk Consultants, Inc., *State of Florida Special Disability Trust Fund Actuarial Review as of June 30, 2015*, at 5, *available at* http://www.myfloridacfo.com/Division/WC/pdf/State-of-Florida-Disability-Trust-Fund_2015_FINAL_09-10-15.pdf.

[53] Email from Andrew Sabolic, Assistant Director of the Division of Workers' Compensation, Department of Financial Services, (Jan. 5, 2016) (on file with Senate Committee on Banking and Insurance).

[54] Office of Judges of Compensation Claims, HB 613 and SB 986 Correspondence (Jan. 8, 2016) (on file with Senate Committee on Banking and Insurance).

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 440.02, 440.021, 440.05, 440.107, 440.13, 440.185, 440.42, 440.49, 440.50, 440.52, and 624.4626.

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.

LEGISLATIVE ACTION

Senate . House

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The Committee on Banking and Insurance (Smith) recommended the following:

Senate Amendment (with title amendment)

Delete lines 45 - 110

and insert:

Section 1. Section 440.021, Florida Statutes, is amended to read:

440.021 Exemption of workers' compensation from chapter 120.—Workers' compensation adjudications by judges of compensation claims are exempt from chapter 120, and no judge of compensation claims shall be considered an agency or a part

thereof. Communications of the result of investigations by the department pursuant to s. 440.185(3) ~~s. 440.185(4)~~ are exempt from chapter 120. In all instances in which the department institutes action to collect a penalty or interest which may be due pursuant to this chapter, the penalty or interest shall be assessed without hearing, and the party against which such penalty or interest is assessed shall be given written notice of such assessment and shall have the right to protest within 20 days of such notice. Upon receipt of a timely notice of protest and after such investigation as may be necessary, the department shall, if it agrees with such protest, notify the protesting party that the assessment has been revoked. If the department does not agree with the protest, it shall refer the matter to the judge of compensation claims for determination pursuant to s. 440.25(2)-(5). Such action of the department is exempt from the provisions of chapter 120.

Section 2. Subsections (1), (2), (3), (5), (10), and (11) of section 440.05, Florida Statutes, are amended to read:

440.05 Election of exemption; revocation of election; notice; certification.—

(1) Each corporate officer who elects not to accept the provisions of this chapter or who, after electing such exemption, revokes that exemption shall submit ~~mail~~ to the department ~~in Tallahassee~~ notice to such effect in accordance with a form to be prescribed by the department.

(2) Each sole proprietor or partner who elects to be included in the definition

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 3 - 7

and insert:

administration; amending s. 440.021, F.S.; conforming a cross-reference; amending s. 440.05, F.S.; deleting a required item to be

By Senator Simpson

18-00585C-16 2016986__

A bill to be entitled

An act relating to workers' compensation system administration; amending s. 440.02, F.S.; revising definitions; amending s. 440.021, F.S.; conforming a cross-reference; amending s. 440.05, F.S.; requiring members of limited liability companies to submit specified notices; deleting a required item to be listed on a notice of election to be exempt; revising specified rules regarding the maintenance of business records by an officer of a corporation; removing the requirement that the Department of Financial Services issue a specified stop-work order; amending s. 440.107, F.S.; requiring that the department allow an employer who has not previously been issued an order of penalty assessment to receive a specified credit to be applied to the penalty; prohibiting the application of a specified credit unless the employer provides specified documentation and proof of payment to the department within a specified period; requiring the department to reduce the final assessed penalty by a specified percentage for employers who have not been previously issued a stop-work order or order of penalty assessment; revising the penalty calculation for the imputed weekly payroll for an employee; amending s. 440.13, F.S.; eliminating the certification requirements when an expert medical advisor is selected by a judge of compensation claims; amending s. 440.185, F.S.; deleting the requirement that employers notify the department within 24 hours

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of any injury resulting in death; amending s. 440.42, F.S.; conforming a cross-reference; amending s. 440.49, F.S.; revising definitions; revising the requirements for filing a claim; deleting the preferred worker program; deleting the notification fees on certain filed claims which supplement the Special Disability Trust Fund; conforming cross-references; amending s. 440.50, F.S.; conforming cross-references; amending s. 440.52, F.S.; deleting a fee for certain registration of insurance carriers; amending s. 624.4626, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Subsection (9) and paragraph (c) of subsection (15) of section 440.02, Florida Statutes, are amended to read:

440.02 Definitions.—When used in this chapter, unless the context clearly requires otherwise, the following terms shall have the following meanings:

(9) "Corporate officer" or "officer of a corporation" means any person who fills an office provided for in the corporate charter or articles of incorporation filed with the Division of Corporations of the Department of State or as authorized or required under part I of chapter 607. For persons engaged in the construction industry, the term "officer of a corporation" includes a member owning at least 10 percent of a limited liability company as defined in and organized pursuant to chapter 605.

(15)

(c) "Employee" includes:

1. A sole proprietor, a member of a limited liability company, or a partner who is not engaged in the construction industry, devotes full time to the proprietorship, limited liability company, or partnership, and elects to be included in the definition of employee by filing notice thereof as provided in s. 440.05.

2. All persons who are being paid by a construction contractor as a subcontractor, unless the subcontractor has validly elected an exemption as permitted by this chapter, or has otherwise secured the payment of compensation coverage as a subcontractor, consistent with s. 440.10, for work performed by or as a subcontractor.

3. An independent contractor working or performing services in the construction industry.

4. A sole proprietor who engages in the construction industry and a partner or partnership that is engaged in the construction industry.

Section 2. Section 440.021, Florida Statutes, is amended to read:

440.021 Exemption of workers' compensation from chapter 120.—Workers' compensation adjudications by judges of compensation claims are exempt from chapter 120, and no judge of compensation claims shall be considered an agency or a part thereof. Communications of the result of investigations by the department pursuant to s. 440.185(3) ~~s. 440.185(4)~~ are exempt from chapter 120. In all instances in which the department institutes action to collect a penalty or interest which may be

due pursuant to this chapter, the penalty or interest shall be assessed without hearing, and the party against which such penalty or interest is assessed shall be given written notice of such assessment and shall have the right to protest within 20 days of such notice. Upon receipt of a timely notice of protest and after such investigation as may be necessary, the department shall, if it agrees with such protest, notify the protesting party that the assessment has been revoked. If the department does not agree with the protest, it shall refer the matter to the judge of compensation claims for determination pursuant to s. 440.25(2)-(5). Such action of the department is exempt from the provisions of chapter 120.

Section 3. Subsections (1), (2), (3), (5), (10), and (11) of section 440.05, Florida Statutes, are amended to read:

440.05 Election of exemption; revocation of election; notice; certification.—

(1) Each corporate officer who elects not to accept the provisions of this chapter or who, after electing such exemption, revokes that exemption shall submit ~~mail~~ to the department ~~in Tallahassee~~ notice to such effect in accordance with a form to be prescribed by the department.

(2) Each sole proprietor, member of a limited liability company, or partner who elects to be included in the definition of "employee" or who, after such election, revokes that election must submit ~~mail~~ to the department ~~in Tallahassee~~ notice to such effect, in accordance with a form to be prescribed by the department.

(3) ~~Each officer of a corporation who is engaged in the construction industry and who elects an exemption from this~~

~~chapter or who, after electing such exemption, revokes that exemption must submit a notice to such effect to the department on a form prescribed by the department.~~ The notice of election to be exempt must be electronically submitted to the department by the officer of a corporation who is allowed to claim an exemption as provided by this chapter and must list the name, ~~federal tax identification number,~~ date of birth, driver license number or Florida identification card number, and all certified or registered licenses issued pursuant to chapter 489 held by the person seeking the exemption, the registration number of the corporation filed with the Division of Corporations of the Department of State, and the percentage of ownership evidencing the required ownership under this chapter. The notice of election to be exempt must identify each corporation that employs the person electing the exemption and must list the social security number or federal tax identification number of each such employer and the additional documentation required by this section. In addition, the notice of election to be exempt must provide that the officer electing an exemption is not entitled to benefits under this chapter, must provide that the election does not exceed exemption limits for officers provided in s. 440.02, and must certify that any employees of the corporation whose officer elects an exemption are covered by workers' compensation insurance. Upon receipt of the notice of the election to be exempt, receipt of all application fees, and a determination by the department that the notice meets the requirements of this subsection, the department shall issue a certification of the election to the officer, unless the department determines that the information contained in the

notice is invalid. The department shall revoke a certificate of election to be exempt from coverage upon a determination by the department that the person does not meet the requirements for exemption or that the information contained in the notice of election to be exempt is invalid. The certificate of election must list the name of the corporation listed in the request for exemption. A new certificate of election must be obtained each time the person is employed by a new or different corporation that is not listed on the certificate of election. A notice ~~copy~~ of the certificate of election must be sent to each workers' compensation carrier identified in the request for exemption. Upon filing a notice of revocation of election, an officer who is a subcontractor or an officer of a corporate subcontractor must notify her or his contractor. Upon revocation of a certificate of election of exemption by the department, the department shall notify the workers' compensation carriers identified in the request for exemption.

(5) A notice given under subsection (1), subsection (2), or subsection (3) shall become effective when issued by the department or 30 days after it ~~an application for an exemption~~ is received by the department, whichever occurs first. However, if an accident or occupational disease occurs less than 30 days after the effective date of the insurance policy under which the payment of compensation is secured or the date the employer qualified as a self-insurer, such notice is effective as of 12:01 a.m. of the day following the date it is submitted ~~mailed~~ to the department ~~in Tallahassee~~.

(10) Each officer of a corporation who is actively engaged in the construction industry and who elects an exemption from

this chapter shall maintain business records as specified by the department by rule~~, which rules must include the provision that any corporation with exempt officers engaged in the construction industry must maintain written statements of those exempted persons affirmatively acknowledging each such individual's exempt status~~.

(11) Any corporate officer permitted by this chapter to claim an exemption must be listed on the records of this state's Secretary of State, Division of Corporations, as a corporate officer. ~~The department shall issue a stop-work order under s. 440.107(7) to any corporation who employs a person who claims to be exempt as a corporate officer but who fails or refuses to produce the documents required under this subsection to the department within 3 business days after the request is made.~~

Section 4. Paragraphs (d) and (e) of subsection (7) of section 440.107, Florida Statutes, are amended to read:

440.107 Department powers to enforce employer compliance with coverage requirements.—

(7)

(d)1. In addition to any penalty, stop-work order, or injunction, the department shall assess against any employer who has failed to secure the payment of compensation as required by this chapter a penalty equal to 2 times the amount the employer would have paid in premium when applying approved manual rates to the employer's payroll during periods for which it failed to secure the payment of workers' compensation required by this chapter within the preceding 2-year period or $1,000, whichever is greater.

a. For employers who have not been previously issued a

stop-work order or order of penalty assessment, the department must allow the employer to receive a credit for the initial payment of the estimated annual workers' compensation policy premium, as determined by the carrier, to be applied to the penalty. Before applying the credit to the penalty, the employer must provide the department with documentation reflecting that the employer has secured the payment of compensation pursuant to s. 440.38 and proof of payment to the carrier. In order for the department to apply a credit for an employer that has secured workers' compensation for leased employees by entering into an employee leasing contract with a licensed employee leasing company, the employer must provide the department with a written confirmation, by a representative from the employee leasing company, of the dollar or percentage amount attributable to the initial estimated workers' compensation expense for leased employees, and proof of payment to the employee leasing company. The credit may not be applied unless the employer provides the documentation and proof of payment to the department within 28 days after service of the stop-work order or first order of penalty assessment upon the employer.

b. For employers who have not been previously issued a stop-work order or order of penalty assessment, the department must reduce the final assessed penalty by 25 percent if the employer has complied with administrative rules adopted pursuant to subsection (5) and has provided such business records to the department within 10 business days after the employer's receipt of the written request to produce business records.

c. The $1,000 penalty shall be assessed against the employer even if the calculated penalty after the credit and 25

percent reduction have ~~has~~ been applied is less than $1,000.

2. Any subsequent violation within 5 years after the most recent violation shall, in addition to the penalties set forth in this subsection, be deemed a knowing act within the meaning of s. 440.105.

(e) When an employer fails to provide business records sufficient to enable the department to determine the employer's payroll for the period requested for the calculation of the penalty provided in paragraph (d), for penalty calculation purposes, the imputed weekly payroll for each employee, corporate officer, sole proprietor, or partner shall be the statewide average weekly wage as defined in s. 440.12(2) multiplied by 1.5 ~~2~~.

Section 5. Paragraph (a) of subsection (7) and paragraphs (a) and (f) of subsection (9) of section 440.13, Florida Statutes, are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(7) UTILIZATION AND REIMBURSEMENT DISPUTES.—

(a) Any health care provider~~, carrier, or employer~~ who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 45 days after receipt of notice of disallowance or adjustment of payment, petition the department to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the department results in dismissal of the

petition.

(9) EXPERT MEDICAL ADVISORS.—

(a) The department shall certify expert medical advisors in each specialty to assist the department ~~and the judges of compensation claims~~ within the advisor's area of expertise as provided in this section. The department shall, in a manner prescribed by rule, in certifying, recertifying, or decertifying an expert medical advisor, consider the qualifications, training, impartiality, and commitment of the health care provider to the provision of quality medical care at a reasonable cost. As a prerequisite for certification or recertification, the department shall require, at a minimum, that an expert medical advisor have specialized workers' compensation training or experience under the workers' compensation system of this state and board certification or board eligibility.

(f) If the department or a judge of compensation claims orders the services of an ~~a certified~~ expert medical advisor to resolve a dispute under this section, the party requesting such examination must compensate the advisor for his or her time in accordance with a schedule adopted by the department. If the employee prevails in a dispute as determined in an order by a judge of compensation claims based upon the expert medical advisor's findings, the employer or carrier shall pay for the costs of such expert medical advisor. If a judge of compensation claims, upon his or her motion, finds that an expert medical advisor is needed to resolve the dispute, the carrier must compensate the advisor for his or her time in accordance with a schedule adopted by the department. The department may assess a

penalty not to exceed $500 against any carrier that fails to timely compensate an advisor in accordance with this section.

Section 6. Subsection (3) of section 440.185, Florida Statutes, is amended to read:

440.185 Notice of injury or death; reports; penalties for violations.—

~~(3) In addition to the requirements of subsection (2), the employer shall notify the department within 24 hours by telephone or telegraph of any injury resulting in death. However, this special notice shall not be required when death results subsequent to the submission to the department of a previous report of the injury pursuant to subsection (2).~~

Section 7. Subsection (3) of section 440.42, Florida Statutes, is amended to read:

440.42 Insurance policies; liability.—

(3) No contract or policy of insurance issued by a carrier under this chapter shall expire or be canceled until at least 30 days have elapsed after a notice of cancellation has been sent to the department and to the employer in accordance with the provisions of s. 440.185(6) ~~s. 440.185(7)~~. For cancellation due to nonpayment of premium, the insurer shall mail notification to the employer at least 10 days prior to the effective date of the cancellation. However, when duplicate or dual coverage exists by reason of two different carriers having issued policies of insurance to the same employer securing the same liability, it shall be presumed that only that policy with the later effective date shall be in force and that the earlier policy terminated upon the effective date of the latter. In the event that both policies carry the same effective date, one of the policies may

be canceled instanter upon filing a notice of cancellation with the department and serving a copy thereof upon the employer in such manner as the department prescribes by rule. The department may by rule prescribe the content of the notice of retroactive cancellation and specify the time, place, and manner in which the notice of cancellation is to be served.

Section 8. Paragraph (b) of subsection (2), paragraph (c) of subsection (4), paragraph (c) of subsection (6), paragraphs (c) and (d) of subsection (7), subsection (8), and paragraph (d) of subsection (9) of section 440.49, Florida Statutes, are amended to read:

440.49 Limitation of liability for subsequent injury through Special Disability Trust Fund.—

(2) DEFINITIONS.—As used in this section, the term:

~~(b) "Preferred worker" means a worker who, because of a permanent impairment resulting from a compensable injury or occupational disease, is unable to return to the worker's regular employment.~~

In addition to the definitions contained in this subsection, the department may by rule prescribe definitions that are necessary for the effective administration of this section.

(4) PERMANENT IMPAIRMENT OR PERMANENT TOTAL DISABILITY, TEMPORARY BENEFITS, MEDICAL BENEFITS, OR ATTENDANT CARE AFTER OTHER PHYSICAL IMPAIRMENT.—

(c) *Temporary compensation and medical benefits; aggravation or acceleration of preexisting condition or circumstantial causation.*—If an employee who has a preexisting permanent physical impairment experiences an aggravation or

acceleration of the preexisting permanent physical impairment as a result of an injury or occupational disease arising out of and in the course of her or his employment, or suffers an injury as a result of a merger as defined in paragraph (2)(b) ~~(2)(c)~~, the employer shall provide all benefits provided by this chapter, but, subject to the limitations specified in subsection (7), the employer shall be reimbursed by the Special Disability Trust Fund created by subsection (9) for 50 percent of its payments for temporary, medical, and attendant care benefits.

(6) EMPLOYER KNOWLEDGE, EFFECT ON REIMBURSEMENT.—

(c) An employer's or carrier's right to apportionment or deduction pursuant to ss. 440.02(1), 440.15(5)(b), and 440.151(1)(c) does not preclude reimbursement from such fund, except when the merger comes within the definition of paragraph (2)(b) ~~(2)(c)~~ and such apportionment or deduction relieves the employer or carrier from providing the materially and substantially greater permanent disability benefits otherwise contemplated in those paragraphs.

(7) REIMBURSEMENT OF EMPLOYER.—

(c) A proof of claim must be filed on each notice of claim on file as of June 30, 1997, within 1 year after July 1, 1997, or the right to reimbursement of the claim shall be barred. A notice of claim on file on or before June 30, 1997, may be withdrawn and refiled if, at the time refiled, the notice of claim remains within the limitation period specified in paragraph (a). Such refiling shall not toll, extend, or otherwise alter in any way the limitation period applicable to the withdrawn and subsequently refiled notice of claim. ~~Each proof of claim filed shall be accompanied by a proof-of-claim~~

~~fee as provided in paragraph (9)(d).~~ The Special Disability Trust Fund shall, within 120 days after receipt of the proof of claim, serve notice of the acceptance of the claim for reimbursement. This paragraph shall apply to all claims notwithstanding the provisions of subsection (12).

(d) ~~Each notice of claim filed or refiled on or after July 1, 1997, must be accompanied by a notification fee as provided in paragraph (9)(d).~~ A proof of claim must be filed within 1 year after the date the notice of claim is filed or refiled~~,~~ ~~accompanied by a proof-of-claim fee as provided in paragraph (9)(d),~~ or the claim shall be barred. ~~The notification fee shall be waived if both the notice of claim and proof of claim are submitted together as a single filing.~~ The Special Disability Trust Fund shall, within 180 days after receipt of the proof of claim, serve notice of the acceptance of the claim for reimbursement. This paragraph shall apply to all claims notwithstanding the provisions of subsection (12).

~~(8) PREFERRED WORKER PROGRAM.—The Department of Education or administrator shall issue identity cards to preferred workers upon request by qualified employees and the Department of Financial Services shall reimburse an employer, from the Special Disability Trust Fund, for the cost of workers' compensation premium related to the preferred workers payroll for up to 3 years of continuous employment upon satisfactory evidence of placement and issuance of payroll and classification records and upon the employee's certification of employment. The Department of Financial Services and the Department of Education may by rule prescribe definitions, forms, and procedures for the administration of the preferred worker program. The Department~~

~~of Education may by rule prescribe the schedule for submission of forms for participation in the program.~~

(8)~~(9)~~ SPECIAL DISABILITY TRUST FUND.—

~~(d) The Special Disability Trust Fund shall be supplemented by a $250 notification fee on each notice of claim filed or refiled after July 1, 1997, and a $500 fee on each proof of claim filed in accordance with subsection (7). Revenues from the fee shall be deposited into the Special Disability Trust Fund and are exempt from the deduction required by s. 215.20. The fees provided in this paragraph shall not be imposed upon any insurer which is in receivership with the department.~~

Section 9. Paragraph (b) of subsection (1) of section 440.50, Florida Statutes, is amended to read:

440.50 Workers' Compensation Administration Trust Fund.—

(1)

(b) The department is authorized to transfer as a loan an amount not in excess of $250,000 from such special fund to the Special Disability Trust Fund established by s. 440.49(8) ~~s. 440.49(9)~~, which amount shall be repaid to the ~~said~~ special fund in annual payments equal to not less than 10 percent of moneys received for the ~~such~~ Special Disability Trust Fund.

Section 10. Subsection (1) of section 440.52, Florida Statutes, is amended to read:

440.52 Registration of insurance carriers; notice of cancellation or expiration of policy; suspension or revocation of authority.—

(1) Each insurance carrier who desires to write workers' ~~such~~ compensation insurance in compliance with this chapter shall be required, before writing such insurance, to register

with the department ~~and pay a registration fee of $100. This shall be deposited by the department in the fund created by s. 440.50~~.

Section 11. Subsection (2) of section 624.4626, Florida Statutes, is amended to read:

624.4626 Electric cooperative self-insurance fund.—

(2) A self-insurance fund that meets the requirements of this section is subject to the assessments set forth in ss. 440.49(8) ~~ss. 440.49(9)~~, 440.51(1), and 624.4621(7), but is not subject to any other provision of s. 624.4621 and is not required to file any report with the department under s. 440.38(2)(b) which is uniquely required of group self-insurer funds qualified under s. 624.4621.

Section 12. This act shall take effect October 1, 2016.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Community Affairs, *Chair*
Environmental Preservation and Conservation, *Vice Chair*
Appropriations Subcommittee on General Government
Finance and Tax
Judiciary
Transportation

JOINT COMMITTEE:
Joint Legislative Auditing Committee

SENATOR WILTON SIMPSON
18th District

December 16, 2015

Honorable Lizbeth Benacquisto
Committee on Banking and Insurance
320 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chairman Benacquisto,

Please place Senate Bill 986 relating to Workers' Compensation System Administration, on the next Banking and Insurance Committee agenda.

Please contact my office with any questions. Thank you.

Wilton Simpson
Senator, 18th District

CC: James Knudson, Staff Director

REPLY TO:
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❒ Post Office Box 938, Brooksville, Florida 34605
❒ Post Office Box 787, New Port Richey, Florida 34656-0787 (727) 816-1120 FAX: (888) 263-4821

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

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 1036
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Automobile Insurance
DATE:	January 27, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Knudson	BI	**Fav/CS**
2.			CM	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1036 makes the following changes relating to automobile insurance:

Use of Rating Territories Contained Within a Single Zip-Code

- Allows motor vehicle insurance rates to be developed using rating territories contained within a single zip code if:
  - The rating territories incorporate sufficient loss and loss adjustment expense data to be actuarially measurable and credible; and
  - The Office of Insurance Regulation (OIR) determines that a rate filing using such rating territories does not contain a rate or rate change that is excessive, inadequate, or unfairly discriminatory.

Cancellation of Policies Issued by the Florida Automobile Joint Underwriting Association

- Allows the Florida Automobile Joint Underwriting Association (Auto JUA) to cancel personal lines or commercial lines policies issued by the plan for nonpayment of premium if a check is dishonored for any reason or any other form of payment is rejected or deemed invalid. The cancellation may only occur within the first 60 days of the policy or binder;
- Prohibits an insured of the Auto JUA from cancelling a policy or binder within the first 90 days of its effective date unless the insured vehicle is totally destroyed, ownership of the vehicle is transferred, or another policy is purchased covering the vehicle;

Payment of Premium and Return of Unearned Premium

- Allows motor vehicle insurers to apply the unearned portion of premium to unpaid balances of other policies with the same insurer or insurer group instead of returning the premium via mail or electronic transfer.
- Specifies that motor vehicle insurance premiums may be paid in cash in the form of a draft or drafts. Allows the insurer to impose an insufficient funds fee of up to $15 per occurrence if specified methods of premium payments are declined for insufficient funds.
- Exempts policies paid via a recurring credit card or debit card agreement with the insurer from the requirement that, prior to issuing or binding a motor vehicle insurance policy, the insured must pay at least 2 months' premium.

Personal Injury Protection (PIP)

- Exempts publicly traded corporations with $250 million or more in total annual sales in health care services from the requirement to obtain health care clinic licensure as a condition of qualifying for reimbursement under PIP coverage.
- Clarifies and updates references to billing requirements under PIP.

Preinsurance Inspection of Private Passenger Motor Vehicles

- Allows insurers to opt out of the preinsurance inspection requirements of the section for private passenger motor vehicles. An insurer that opts out of the statutory preinsurance inspection process must file a manual rule notifying the OIR that it is doing so, and may establish its own preinsurance inspection program.

The effective date is July 1, 2016.

II. Present Situation:

Zip Codes and Rating Territories for Motor Vehicle Insurance

Section 627.062, F.S., is Florida's rating law. Among other requirements, it provides that insurance rates cannot be excessive, inadequate, or unfairly discriminatory. Insurer rate filings that comply with the law and are adequately supported by actuarial justification must be accepted by the OIR. Pursuant to s. 627.0651, F.S., the use of a single zip code as a rating territory for motor vehicle insurance rates is deemed unfairly discriminatory and is thus prohibited.

Cancellation of Florida Automobile Joint Underwriting Association Policies

Insurers[1] that offer motor vehicle insurance in the state must participate in the Auto JUA.[2] The Auto JUA exists to provide motor vehicle insurance to individuals who cannot obtain such coverage in the voluntary insurance market. The Auto JUA distributes this risk among its members. It is subject to various limitations regarding issuance and cancellation of coverage, and

[1] s. 624.03, F.S.
[2] s. 627.311, F.S.

provision of premium credits/discounts to protect its solvency, the coverage of its insureds, and to avoid Auto JUA policies being competitive with the voluntary market.
Motor vehicle insurers, including the Auto JUA, are limited regarding the cancellation of insurance policies.[3] An insurer may not cancel a policy within 60 days of the effective date of the policy, except for non-payment of premium.[4]

Return of Unearned Premium upon Cancellation of Motor Vehicle Insurance

Section 627.7283, F.S., requires insurers to mail or electronically transfer the unearned portion of any premium paid on a motor vehicle insurance policy. If the insured cancels the policy, the insurer must return the unearned premium within 30 days upon the later of the policy cancellation or the receipt of notice of policy cancellation. If the insurer cancels the policy, the unearned premium must be returned within 15 days of the effective date of the policy cancellation.

Requirement to Initially Pay 2 Months' Premium before Issuance of Private Passenger Motor Vehicle Insurance

Before a policy of private passenger motor vehicle insurance may be initially issued or bound, s. 627.7295(7), F.S., requires the insurer or insurance agent to collect 2 months' premium from the insured before the effective date of the policy. This requirement does not apply:

- To policy renewals or replacement policies issued by the same insurer group;
- To an insurer that issues private passenger motor vehicle insurance policies primarily to active duty or former personnel or their dependents;
- If all policy payments are paid pursuant to a payroll deduction plan or an automatic electronic funds transfer payment from the policyholder;
- If all policy payments are paid pursuant to an automatic electronic funds transfer payment plan from an agent, a managing general agent, or a premium finance company if the policy includes Personal Injury Protection (PIP) insurance, property damage liability coverage of at least $10,000, and bodily injury liability coverage of at least $10,000 per person and $20,000 per accident; or
- If the insured had a policy in effect for at least 6 months, the insured's agent is terminated by the insurer that issued the policy; and the insured obtains coverage on the policy's renewal date with a new company through the terminated agent.

Personal Injury Protection Insurance – Billings for Medical Services

Florida's Motor Vehicle No-Fault Law (the "No-Fault Law")[5] requires motorists to carry personal injury protection (PIP) coverage. Personal injury protection coverage provides $10,000 in medical and disability benefits and a $5,000 death benefit.[6] Medical benefits are limited to $2,500 if the injured person is determined to not have an emergency medical condition.[7] The purpose of the No-Fault Law is to provide for medical, surgical, funeral, and disability insurance

[3] ss. 627.7295 and 627.728, F.S.
[4] s. 627.7295(4), F.S.
[5] ss. 627.730-627.7405, F.S.
[6] s. 627.736(1), F.S.
[7] s. 627.736(1)(a)4., F.S.

benefits without regard to fault. In return for assuring payment of these benefits, the No-Fault Law provides limitations on the right to bring lawsuits arising from motor vehicle accidents.[8]

Section 627.736(5)(d), F.S., requires all statements and bills for medical services reimbursable by PIP to be submitted according to specified criteria. The billings must be on properly completed Centers for Medicare and Medicaid Services (CMS) 1500 forms, UB 92 forms, or any other standard form approved by the OIR or adopted by the Financial Services Commission. Billings must, to the extent applicable, follow the Physicians' Current Procedural Terminology (CPT)[9] or Healthcare Correct Procedural Coding System (HCPCS)[10] or the International Classification of Diseases[11] (ICD-9). Though the No-Fault Law requires use of the ICD-9, the current updated version is the ICD-10.[12]

Personal Injury Protection Insurance –Health Care Clinic Licensure

The No-Fault Law requires entities that seek reimbursement under PIP coverage to obtain licensure under the Health Care Clinic Act[13], unless exempt from this requirement. The purpose of the Health Care Clinic Act is to provide for the licensure, establishment, and enforcement of basic standards for health care clinics and to provide administrative oversight by the AHCA.[14] The exemptions include:

- Hospitals licensed under ch. 395, F.S.
- Ambulatory surgical cetners licensed under ch. 395, F.S.
- An entity that wholly owns or is wholly owned by a hospital licensed under ch. 395, F.S.
- An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.
- Entities wholly owned by:
  - Physicians licensed under ch. 458, F.S., or ch. 459, F.S.;
  - Dentists licensed under ch. 466, F.S.;
  - Chiropractic physicians licensed under ch. 460;
- An entity certified under 42 C.F.R. part 485, subpart H (entities qualified under Medicare to provide outpatient physical therapy and speech pathology services).

Preinsurance Inspection of Private Passenger Motor Vehicles

Section 627.744, F.S., requires insurers to perform preinsurance inspections of private passenger motor vehicles. It also provides various exemptions from the required preinsurance inspection,

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[8] s. 627.737, F.S.
[9] The American Medical Association CPT codes, provide standardized nomenclature used to report medical procedures and services. *See* American Medical Association, *About CPT®*, http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.page (last visited Jan. 22, 2016).
[10] The HCPCS contains codes for products, supplies, and services not included in CPT codes such as durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office. *See* Centers for Medicaid & Medicare Services, HCPCS – General Information HCPCS Background Information, https://www.cms.gov/medicare/coding/medhcpcsgeninfo/index.html (last visited Jan. 22, 2016).
[11] The ICD classifies diseases and other health problems and is used by health care providers and insurers.
[12] World Health Organization, *International Classification of Diseases (ICD)*, http://www.who.int/classifications/icd/en/ (Last visited Jan. 22, 2016).
[13] Sections 400.990 – 400.995, F.S.
[14] Section 400.990, F.S.

including for new, unused motor vehicles "purchased" from a licensed motor vehicle dealer or leasing company when the insurer is provided with the bill of sale, buyer's order, or copy of the title and certain other documentation.

Despite the exemptions, an insurer may require a preinsurance inspection of any motor vehicle as a condition of issuance of physical damage coverage. Physical damage coverage may not be suspended during the policy period due to the applicant's failure to provide the required documents. However, claim payments are conditioned upon and are not payable until the required documents are received by the insurer. Applicants for insurance may be required to pay the cost of the preinsurance inspection, not to exceed $5.

III. Effect of Proposed Changes:

Use of Rating Territories Contained Within a Single Zip-Code

Section 1 amends s. 627.0651, F.S., to allow motor vehicle insurance rates to be developed using rating territories contained within a single zip code if:

- The rating territories incorporate sufficient loss and loss adjustment expense data to be actuarially measurable and credible; and
- The Office of Insurance Regulation (OIR) determines that a rate filing using such rating territories does not contain a rate or rate change that is excessive, inadequate, or unfairly discriminatory.

Florida Automobile Joint Underwriting Association Policies – Cancellation for Non-Payment of Premium

Section 2 amends s. 627.311(3), F.S., to allow the Florida Automobile Joint Underwriting Association to cancel personal or commercial lines policies issued by the plan for nonpayment of premium if a check is dishonored for any reason or any other form of payment is rejected or deemed invalid. The cancellation may only occur within the first 60 days of the policy or binder. The bill prohibits the insured of the Association from cancelling a policy or binder within the first 90 days of its effective date except if the insured motor vehicle is totally destroyed, ownership of the vehicle is transferred, or after the purchase of another policy or binder covering the motor vehicle.

Motor Vehicle Insurance – Return of Unearned Premium upon Cancellation

Section 3 amends s. 627.7283, F.S., which sets the requirements for insurers to return unearned premium to policyholders when insurance policies are cancelled by the insured or insurer. The bill allows motor vehicle insurers to apply the unearned portion of premium to unpaid balances of other policies with the same insurer or insurer group instead of returning the premium via mail or electronic transfer.

Motor Vehicle Insurance – Methods of Premium Payment

Section 4 amends s. 627.7295, F.S., to exempt policies paid via a recurring credit card or debit card agreement with the insurer from the requirement that, prior to issuing or binding a motor vehicle insurance policy, the insured must pay at least 2 months' premium.

The bill also authorizes premiums to be paid in cash in the form of a draft or drafts. The bill allows the insurer to impose an insufficient funds fee of up to $15 per occurrence if a payment via draft made by debit card, credit card, or automatic electronic funds transfer is returned, declined, or cannot be processed due to insufficient funds.

Personal Injury Protection

Section 5 amends s. 627.736(5)(d), F.S., to clarify that billings under the Motor Vehicle No-Fault law must follow the Physicians Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System in effect for the year in which services are rendered, and the International Classification of Diseases (ICD) adopted by the United States Department of Health and Human Services for the year in which services are rendered. Compliance with all three standardizes PIP billings and facilitates the timely adjustment and payment of benefits. The bill will require compliance with the current version of the ICD, the ICD-10.

The bill also exempts publicly traded corporations with $250 million or more in total annual sales in health care services from the requirement to obtain health care clinic licensure as a condition of qualifying for reimbursement under PIP coverage.

Insurer Opt-out of Statutory Preinsurance Inspection

Section 6 amends s. 627.744, F.S., to allow insurers to opt out of the preinsurance inspection requirements of the section for private passenger motor vehicles. An insurer that opts out of the statutory preinsurance inspection process must file a manual rule notifying the OIR that it is doing so, and may establish its own preinsurance inspection program.

Effective Date

Section 7 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Policyholders of motor vehicle insurance will be subject to an insufficient funds fee of up to $15 if payment by debit card, credit card, or automatic electronic funds transfer is returned, declined, or cannot be processed because of insufficient funds.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill authorizes the payment of motor vehicle insurance premiums via cash by draft. However, s. 627.4035, F.S., currently allows payment by cash, check, debit card, credit card and electronic funds transfer. It is unclear what additional methods are captured by the bill. The $15 insufficient funds fee authorized by the bill only applies to debit card, credit card, or automatic electronic funds transfer, all of which are currently available methods of payment under s. 627.4035, F.S., and thus would not apply to the additional methods of "draft" payment, if any, that are authorized by the bill.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.0651, 627.311, 627.7283, 627.7295, 627.736, and 627.744.

IX. Additional Information:

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

CS by Banking and Insurance January 26, 2016:
The CS:

- Allows motor vehicle insurance rates to be developed using rating territories contained within a single zip code if specified requirements are met;
- Specifies that motor vehicle insurance premiums may be paid in cash in the form of a draft or drafts. Allows the insurer to impose an insufficient funds fee of up to $15 per occurrence if specified methods of premium payments are declined for insufficient funds;

- Exempts publicly traded corporations with $250 million or more in total annual sales in health care services from the requirement to obtain health care clinic licensure as a condition of qualifying for reimbursement under PIP coverage.

B. Amendments:

None.

911596

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/27/2016	.	
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	.	
	.	

The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment (with title amendment)

Before line 36
insert:
Section 1. Subsection (8) of section 627.0651, Florida Statutes, is amended to read:
627.0651 Making and use of rates for motor vehicle insurance.—
(8) Rates are not unfairly discriminatory if averaged

911596

broadly among members of a group; nor are rates unfairly discriminatory even though they are lower than rates for nonmembers of the group. However, such rates are unfairly discriminatory if they are not actuarially measurable and credible and sufficiently related to actual or expected loss and expense experience of the group so as to assure that nonmembers of the group are not unfairly discriminated against. Use of a single United States Postal Service zip code as a rating territory shall be deemed unfairly discriminatory unless filed pursuant to paragraph (1)(a) and the territory incorporates sufficient actual or expected loss and loss adjustment expense experience so as to be actuarially measurable and credible. The office shall ensure that any rate filing resulting from the use of a single zip code as a rating territory does not contain a rate or rate change that is excessive, inadequate, or unfairly discriminatory.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete line 2

and insert:

An act relating to automobile insurance; amending s. 627.0651, F.S.; providing an exception to a provision that deems use of a single zip code as a rating territory for insurance rates to be unfairly discriminatory; requiring the Office of Insurance Regulation to ensure that rates or rate changes contained in certain rate filings are not excessive, inadequate, or unfairly discriminatory; amending s.

683016

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/27/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment (with directory and title amendments)

Delete lines 154 - 217
and insert:
(9)(a) In addition to the methods provided in s. 627.4035(1), the premiums for motor vehicle insurance contracts issued in this state or covering risk located in this state may be paid in cash in the form of a draft or drafts.
(b) If a payment of premium under this subsection by debit card, credit card, or automatic electronic funds transfer is

683016

returned or declined or cannot be processed due to insufficient funds, the insurer may impose an insufficient funds fee of up to $15 per occurrence pursuant to the policy terms.

Section 1. Paragraphs (d) and (h) of subsection (5) of section 627.736, Florida Statutes, are amended to read:

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

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(d) All statements and bills for medical services rendered by a physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office and ~~or~~ adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers must, to the extent applicable, comply with the CMS 1500 form instructions, the American Medical Association CPT Editorial Panel, and the Healthcare Common Procedure Coding System (HCPCS); and must follow the Physicians' Current Procedural Terminology (CPT), the HCPCS in effect for the year in which services are rendered, and the International Classification of Diseases (ICD) adopted by the United States Department of Health and Human Services for the service year in which the services, supplies, or care is rendered as described in subparagraph (a)2. ~~follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the CMS 1500 form instructions, the American Medical Association CPT Editorial Panel, and the HCPCS.~~ All providers, other than

hospitals, must include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the ~~Physicians' Current Procedural Terminology (~~CPT~~)~~ or the ~~Healthcare Correct Procedural Coding System (~~HCPCS~~)~~ in effect for the year in which services were rendered, the Office of the Inspector General, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is not considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

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

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

2. An entity wholly owned by a dentist licensed under

683016

chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist;

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

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

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

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

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

8. An entity that is owned by a publicly traded corporation, either directly or indirectly through its subsidiaries, that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners, if one or more of the persons responsible for the operations of the entity are health care practitioners who are licensed in this state and are responsible for supervising the business activities of the entity and the entity's compliance with state law for purposes of this section.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======

And the directory clause is amended as follows:

683016

Delete line 115

and insert:

Statutes, is amended, and a new subsection (9) is added to that section, to read:

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 17 - 26

and insert:

payments; authorizing an additional form of payment for certain motor vehicle insurance contract premiums; authorizing an insurer to impose a specified insufficient funds fee under certain circumstances; amending s. 627.736, F.S.; requiring that a certain standard form be approved by the office and adopted by the Financial Services Commission, rather than approved by the office or adopted by the commission; revising standards for compliance for specified billings for medical services; adding a specified entity to a list of entities that are not required to be licensed as a clinic to receive reimbursement under the Florida Motor Vehicle No-Fault Law;

By Senator Brandes

22-00805D-16 20161036__

A bill to be entitled

An act relating to automobile insurance; amending s. 627.311, F.S.; authorizing the Florida Automobile Joint Underwriting Association and a joint underwriting plan approved by the Office of Insurance Regulation to cancel personal lines or commercial policies within a specified time for nonpayment of premium due to certain reasons; prohibiting an insured from cancelling a policy or binder within a specified time except under certain conditions; amending s. 627.7283, F.S.; authorizing an insured who cancels a policy to apply the unearned portion of any premium paid to unpaid balances of other policies with the same insurer or insurer group; amending s. 627.7295, F.S.; updating applicability language to include a reference to recurring credit card or debit card payments; amending s. 627.736, F.S.; requiring that a certain standard form be approved by the office and adopted by the Financial Services Commission, rather than approved by the office or adopted by the commission; revising standards for compliance for specified billings for medical services; amending s. 627.739, F.S.; revising applicability; providing a limitation to an amount of expenses and losses applicable to a deductible related to personal injury protection benefits under a certain condition; amending s. 627.744, F.S.; authorizing an insurer to opt out of the preinsurance inspection of private passenger motor vehicles and to establish its own

22-00805D-16 20161036__

preinsurance inspection program if it files a certain manual rule with the office; providing an effective date.

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

Section 1. Paragraph (m) is added to subsection (3) of section 627.311, Florida Statutes, to read:

627.311 Joint underwriters and joint reinsurers; public records and public meetings exemptions.—

(3) The office may, after consultation with insurers licensed to write automobile insurance in this state, approve a joint underwriting plan for purposes of equitable apportionment or sharing among insurers of automobile liability insurance and other motor vehicle insurance, as an alternate to the plan required in s. 627.351(1). All insurers authorized to write automobile insurance in this state shall subscribe to the plan and participate therein. The plan shall be subject to continuous review by the office which may at any time disapprove the entire plan or any part thereof if it determines that conditions have changed since prior approval and that in view of the purposes of the plan changes are warranted. Any disapproval by the office shall be subject to the provisions of chapter 120. The Florida Automobile Joint Underwriting Association is created under the plan. The plan and the association:

(m) May cancel personal lines or commercial policies issued by the plan within the first 60 days after the effective date of the policy or binder for nonpayment of premium if the check issued for payment of the premium is dishonored for any reason

or if any other form of payment is rejected or deemed invalid. An insured may not cancel a policy or binder within the first 90 days after its effective date, or within a lesser period as required by the plan, except:

1. Upon total destruction of the insured motor vehicle;

2. Upon transfer of ownership of the insured motor vehicle; or

3. After purchase of another policy or binder covering the motor vehicle that was covered under the policy being canceled.

Section 2. Section 627.7283, Florida Statutes, is amended to read:

627.7283 Cancellation; return of unearned premium.—

(1) If the insured cancels a policy of motor vehicle insurance, the insurer must mail or electronically transfer the unearned portion of any premium paid within 30 days after the effective date of the policy cancellation or receipt of notice or request for cancellation, whichever is later. This requirement applies to a cancellation initiated by an insured for any reason. However, the insured may apply the unearned portion of any premium paid to unpaid balances of other policies with the same insurer or insurer group.

(2) If an insurer cancels a policy of motor vehicle insurance, the insurer must mail or electronically transfer the unearned premium portion of any premium within 15 days after the effective date of the policy cancellation. However, the insured may apply the unearned portion of any premium paid to unpaid balances of other policies with the same insurer or insurer group.

(3) If the unearned premium is not mailed, ~~or~~

electronically transferred, or applied to the unpaid balance of other policies within the applicable period, the insurer must pay to the insured 8 percent interest on the amount due. If the unearned premium is not mailed or electronically transferred within 45 days after the applicable period, the insured may bring an action against the insurer pursuant to s. 624.155.

(4) If the insured cancels, the insurer may retain up to 10 percent of the unearned premium and must refund at least 90 percent of the unearned premium. If the insurer cancels, the insurer must refund 100 percent of the unearned premium. Cancellation is without prejudice to any claim originating prior to the effective date of the cancellation. For purposes of this section, unearned premiums must be computed on a pro rata basis.

(5) The insurer must refund 100 percent of the unearned premium if the insured is a servicemember, as defined in s. 250.01, who cancels because he or she is called to active duty or transferred by the United States Armed Forces to a location where the insurance is not required. The insurer may require a servicemember to submit either a copy of the official military orders or a written verification signed by the servicemember's commanding officer to support the refund authorized under this subsection. If the insurer cancels, the insurer must refund 100 percent of the unearned premium. Cancellation is without prejudice to any claim originating prior to the effective date of the cancellation. For purposes of this section, unearned premiums must be computed on a pro rata basis.

Section 3. Subsection (7) of section 627.7295, Florida Statutes, is amended to read:

627.7295 Motor vehicle insurance contracts.—

(7) A policy of private passenger motor vehicle insurance or a binder for such a policy may be initially issued in this state only if, before the effective date of such binder or policy, the insurer or agent has collected from the insured an amount equal to 2 months' premium. An insurer, agent, or premium finance company may not, directly or indirectly, take any action resulting in the insured having paid from the insured's own funds an amount less than the 2 months' premium required by this subsection. This subsection applies without regard to whether the premium is financed by a premium finance company or is paid pursuant to a periodic payment plan of an insurer or an insurance agent. This subsection does not apply if an insured or member of the insured's family is renewing or replacing a policy or a binder for such policy written by the same insurer or a member of the same insurer group. This subsection does not apply to an insurer that issues private passenger motor vehicle coverage primarily to active duty or former military personnel or their dependents. This subsection does not apply if all policy payments are paid pursuant to a payroll deduction plan, ~~or~~ an automatic electronic funds transfer payment plan from the policyholder, or a recurring credit card or debit card agreement with the insurer. This subsection and subsection (4) do not apply if all policy payments to an insurer are paid pursuant to an automatic electronic funds transfer payment plan from an agent, a managing general agent, or a premium finance company and if the policy includes, at a minimum, personal injury protection pursuant to ss. 627.730-627.7405; motor vehicle property damage liability pursuant to s. 627.7275; and bodily injury liability in at least the amount of $10,000 because of

bodily injury to, or death of, one person in any one accident and in the amount of $20,000 because of bodily injury to, or death of, two or more persons in any one accident. This subsection and subsection (4) do not apply if an insured has had a policy in effect for at least 6 months, the insured's agent is terminated by the insurer that issued the policy, and the insured obtains coverage on the policy's renewal date with a new company through the terminated agent.

Section 4. Paragraph (d) of subsection (5) of section 627.736, Florida Statutes, is amended to read:

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

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(d) All statements and bills for medical services rendered by a physician, hospital, clinic, or other person or institution shall be submitted to the insurer on a properly completed Centers for Medicare and Medicaid Services (CMS) 1500 form, UB 92 forms, or any other standard form approved by the office and ~~or~~ adopted by the commission for purposes of this paragraph. All billings for such services rendered by providers must, to the extent applicable, comply with the CMS 1500 form instructions, the American Medical Association CPT Editorial Panel, and the Healthcare Common Procedure Coding System (HCPCS); and must follow the Physicians' Current Procedural Terminology (CPT), the HCPCS in effect for the year in which services are rendered, and the International Classification of Diseases (ICD) adopted by the United States Department of Health and Human Services for the year in which services are rendered ~~follow the Physicians' Current Procedural Terminology (CPT) or Healthcare Correct~~

~~Procedural Coding System (HCPCS), or ICD-9 in effect for the year in which services are rendered and comply with the CMS 1500 form instructions, the American Medical Association CPT Editorial Panel, and the HCPCS~~. All providers, other than hospitals, must include on the applicable claim form the professional license number of the provider in the line or space provided for "Signature of Physician or Supplier, Including Degrees or Credentials." In determining compliance with applicable CPT and HCPCS coding, guidance shall be provided by the ~~Physicians' Current Procedural Terminology (~~CPT~~)~~ or the ~~Healthcare Correct Procedural Coding System (~~HCPCS~~)~~ in effect for the year in which services were rendered, the Office of the Inspector General, Physicians Compliance Guidelines, and other authoritative treatises designated by rule by the Agency for Health Care Administration. A statement of medical services may not include charges for medical services of a person or entity that performed such services without possessing the valid licenses required to perform such services. For purposes of paragraph (4)(b), an insurer is not considered to have been furnished with notice of the amount of covered loss or medical bills due unless the statements or bills comply with this paragraph and are properly completed in their entirety as to all material provisions, with all relevant information being provided therein.

Section 5. Subsection (2) of section 627.739, Florida Statutes, is amended to read:

627.739 Personal injury protection; optional limitations; deductibles.—

(2) Insurers shall offer to each applicant and to each

policyholder, upon the renewal of an existing policy, deductibles, in amounts of $250, $500, and $1,000. The deductible amount must be applied to 100 percent of the expenses and losses covered under personal injury protection benefits coverage issued pursuant to ~~described in~~ s. 627.736. If an insurer has elected to apply the schedule of maximum charges authorized under this chapter, the amount of expenses and losses applicable to the deductible will be limited to 100 percent of such authorized reimbursement limitations or fee schedules. After the deductible is met, each insured is eligible to receive up to $10,000 in total benefits described in s. 627.736(1). However, this subsection shall not be applied to reduce the amount of any benefits received in accordance with s. 627.736(1)(c).

Section 6. Section 627.744, Florida Statutes, is amended to read:

627.744 ~~Required~~ Preinsurance inspection of private passenger motor vehicles.—

(1) A private passenger motor vehicle insurance policy providing physical damage coverage, including collision or comprehensive coverage, may not be issued in this state unless the insurer has inspected the motor vehicle in accordance with this section or has opted out of the inspection under this section. An insurer opting out of the inspection must file a manual rule with the office indicating that the insurer will not be participating in the inspection program under this section and will not require the preinsurance inspection of its insureds' motor vehicles. An insurer that files such a manual rule with the office may establish its own preinsurance

inspection program.

(2) This section does not apply:

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

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

1. A bill of sale, buyer's order, or lease agreement that contains a full description of the motor vehicle; or

2. A copy of the title or registration that establishes transfer of ownership from the dealer or leasing company to the customer and a copy of the window sticker.

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

(c) To a temporary substitute motor vehicle.

(d) To a motor vehicle which is leased for less than 6 months, if the insurer receives the lease or rental agreement

containing a description of the leased motor vehicle, including its condition. Payment of a physical damage claim is conditioned upon receipt of the lease or rental agreement.

(e) To a vehicle that is 10 years old or older, as determined by reference to the model year.

(f) To any renewal policy.

(g) To a motor vehicle policy issued in a county with a 1988 estimated population of less than 500,000.

(h) To any other vehicle or policy exempted by rule of the commission. The commission may base a rule under this paragraph only on a determination that the likelihood of a fraudulent physical damage claim is remote or that the inspection would cause a serious hardship to the insurer or the applicant.

(i) When the insurer's authorized inspection service has no inspection facility either in the municipality in which the automobile is principally garaged or within 10 miles of such municipality.

(j) When the insured vehicle is insured under a commercially rated policy that insures five or more vehicles.

(k) When an insurance producer is transferring a book of business from one insurer to another.

(l) When an individual insured's coverage is being transferred and initiated by a producer to a new insurer.

(3) This subsection does not prohibit an insurer from requiring a preinsurance inspection of any motor vehicle as a condition of issuance of physical damage coverage.

(4) The inspection required by this section shall be provided by the insurer or by a person or organization authorized by the insurer. The applicant may be required to pay

the cost of the inspection, not to exceed $5. The inspection shall be recorded on a form prescribed by the commission, and the form or a copy shall be retained by the insurer with its policy records for the insured. The insurer shall provide a copy of the form to the insured upon request. Any inspection fee paid directly by the applicant may not be considered part of the premium. However, an insurer that provides the inspection at no cost to the applicant may include the expense of the inspection within a rate filing.

(5) The inspection shall include at least the following:

(a) Taking a physical imprint of the vehicle identification number of the vehicle or otherwise recording the vehicle identification number in a manner prescribed by the commission.

(b) Recording the presence of accessories required by the commission to be recorded.

(c) Recording the locations of and a description of existing damage to the vehicle.

(6) An insurer may defer an inspection for 30 calendar days following the effective date of coverage for a new policy, but not for a renewal policy, and for additional or replacement vehicles to an existing policy, if an inspection at the time of the request for coverage would create a serious inconvenience for the applicant and such hardship is documented in the insured's policy record.

(7) The commission may, by rule, establish such procedures and notice requirements that it finds necessary to implement this section.

Section 7. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: December 18, 2015

I respectfully request that **Senate Bill #1036**, relating to **Automobile Insurance**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 22

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/14
Meeting Date

1036
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Jennifer West

Job Title Executive Director

Address PO Box 14956
Street

Tallahassee FL 32317
City *State* *Zip*

Phone 850 933 8514

Email jwest@consumerfedsofse.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Consumer Federation of the Southeast

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-16
Meeting Date

1036
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Mario Gonzalez

Job Title Medmark

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Medmark

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/15
Meeting Date

1036
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name David Altmaier

Job Title Deputy Commissioner

Address _____
Street

Phone 850-413-3849

_____
City *State* *Zip*

Email david.altmaier@floir.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Office of Ins Reg

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

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 1120
INTRODUCER:	Banking and Insurance Committee and Senator Abruzzo
SUBJECT:	Motor Vehicle Service Agreement Companies
DATE:	January 27, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Fav/CS**
2.			CM	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1120 allows motor vehicle service agreements to warrant the following:

- The replacement of tires or wheels on a motor vehicle damaged as a result of encountering a road hazard.
- The replacement of a motor vehicle key or key fob.

The bill also clarifies that an "additive product" does not include a product applied to the exterior or interior surface of a motor vehicle to protect the appearance of the motor vehicle.

The effective date of the bill is July 1, 2016.

II. Present Situation:

Chapter 634, F.S., governs the regulation of warranty associations. Warranty associations include motor vehicle service agreement companies,[1] home warranty associations,[2] and service warranty associations.[3] Each type of warranty association product is governed by applicable provisions of ch. 631, F.S., and is exempt from all other provisions of the Florida Insurance Code unless otherwise specified.[4]

[1] s. 634.011, F.S.
[2] s. 634.301, F.S.
[3] s. 634.401, F.S.
[4] ss. 634.023, 634.3025, and 634.4025, F.S.

Motor vehicle service agreements are defined as indemnifying the service agreement holder (owner) of the motor vehicle listed on the service agreement from losses caused by the failure or improper function of any mechanical or other component part arising out of the ownership, operation, and use of the motor vehicle.[5] Included in the definition are agreements that provide for coverage issued in conjunction with an additive product applied to the motor vehicle, payment of vehicle protection expenses, and payment for paintless dent-removal services.

While a motor vehicle service agreement is not considered a traditional insurance product, it protects purchasers from future risks and associated costs. In Florida, motor vehicle service agreements are regulated by the Office of Insurance Regulation (OIR). The OIR's regulatory authority of warranty associations includes disapproval of noncompliant forms,[6] investigation of complaints,[7] and monitoring of reserve requirements,[8] among other duties. The OIR is not, however, required to approve rates for such warranties.

III. Effect of Proposed Changes:

The bill allows motor vehicle service agreements to warrant the following:

- The replacement of tires or wheels on a motor vehicle damaged as a result of encountering a "road hazard." The bill defines "road hazard" to mean a danger that is encountered while operating a motor vehicle, which includes but is not limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs, and composite scraps. Road hazard specifically does not include any damage caused by collision with another vehicle, vandalism, or other causes usually covered under the comprehensive or collision coverages provided by an automobile physical damage policy.
- The replacement of a motor vehicle key or key fob if the key or key fob is inoperable, lost, or stolen.

The bill also:

- Clarifies that an "additive product" does not include a product applied to the exterior or interior surface of a motor vehicle to protect the appearance of the motor vehicle.
- Removes the reference to hail damage in the explanation for the process of paintless dent removal, which under current law and the bill may be the subject of a motor vehicle service agreement. There are other causes of damage covered under a motor vehicle service agreement for paintless dent removal, hail damage is just one of them. Naming just one cause (hail damage) in statute was viewed as not necessary without listing by name all the other causes.

The effective date of the bill is July 1, 2016.

[5] s. 634.011(8), F.S.
[6] See s. 634.1213, F.S.
[7] See s. 634.141(2)(c), F.S.
[8] See s. 634.141(2)(d), F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

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 634.011 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 26, 2016:
Removes lines 96-97 regarding other services approved by the Commissioner of Insurance.

- Clarifies the definition of "Road Hazard" does not include any damage caused by collision with another vehicle, vandalism, or other causes usually covered under the comprehensive or collision coverages provided by an automobile physical damage policy.

B. Amendments:

None.

216566

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Clemens) recommended the following:

Senate Amendment

Delete lines 93 - 108
and insert:
using replacement body panels or sanding, bonding, or painting; or

(e) For replacement of a motor vehicle key or key fob if the key or key fob is inoperable, lost, or stolen ~~For the payment for paintless dent-removal services provided by a company whose primary business is providing such services~~.

~~2. "Paintless dent-removal" means the process of removing dents, dings, and creases, including hail damage, from a vehicle without affecting the existing paint finish, but does not include services that involve the replacement of vehicle body panels or sanding, bonding, or painting~~.

(14) "Road hazard" means a danger that is encountered while operating a motor vehicle. The term includes, but is not limited to, potholes, rocks, debris, metal parts, glass, plastic, curbs, and composite scraps. The term does not include any damage caused by collision with another vehicle, vandalism, or other causes usually covered under the comprehensive or collision coverages provided by an automobile physical damage policy.

By Senator Abruzzo

25-01372-16 20161120__

A bill to be entitled

An act relating to motor vehicle service agreement companies; amending s. 634.011, F.S.; revising and providing definitions; providing an effective date.

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

Section 1. Subsections (14) through (17) of section 634.011, Florida Statutes, are renumbered as subsections (15) through (18), respectively, subsections (2) and (8) of that section are amended, and a new subsection (14) is added to that section, to read:

634.011 Definitions.—As used in this part, the term:

(2) "Additive product" means any fuel supplement, oil supplement, or any other supplement product added to a motor vehicle for the purpose of increasing or enhancing the performance or improving the longevity of such motor vehicle. The term "additive product" does not include a product applied to the exterior or interior surface of a motor vehicle to protect the appearance of the motor vehicle.

(8) "Motor vehicle service agreement" or "service agreement" means any contract or agreement indemnifying the service agreement holder for the motor vehicle listed on the service agreement and arising out of the ownership, operation, and use of the motor vehicle 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; however, nothing in this part shall prohibit or affect the giving, free of charge, of the usual performance guarantees by manufacturers or dealers in connection with the sale of motor vehicles. Transactions exempt under s. 624.125 are expressly excluded from this definition and are exempt from the provisions

25-01372-16 20161120__

of this part. The term "motor vehicle service agreement" includes any contract or agreement that provides:

(a) For the coverage or protection defined in this subsection and which is issued or provided in conjunction with an additive product applied to the motor vehicle that is the subject of such contract or agreement;

(b) For payment of vehicle protection expenses.

1.a. "Vehicle protection expenses" means a preestablished flat amount payable for the loss of or damage to a vehicle or expenses incurred by the service agreement holder for loss or damage to a covered vehicle, including, but not limited to, applicable deductibles under a motor vehicle insurance policy; temporary vehicle rental expenses; expenses for a replacement vehicle that is at least the same year, make, and model of the stolen motor vehicle; sales taxes or registration fees for a replacement vehicle that is at least the same year, make, and model of the stolen vehicle; or other incidental expenses specified in the agreement.

b. "Vehicle protection product" means a product or system installed or applied to a motor vehicle or designed to prevent the theft of the motor vehicle or assist in the recovery of the stolen motor vehicle.

2. Vehicle protection expenses shall be payable in the event of loss or damage to the vehicle as a result of the failure of the vehicle protection product to prevent the theft of the motor vehicle or to assist in the recovery of the stolen motor vehicle. Vehicle protection expenses covered under the agreement shall be clearly stated in the service agreement form, unless the agreement provides for the payment of a

preestablished flat amount, in which case the service agreement form shall clearly identify such amount.

3. Motor vehicle service agreements providing for the payment of vehicle protection expenses shall either:

a. Reimburse a service agreement holder for the following expenses, at a minimum: deductibles applicable to comprehensive coverage under the service agreement holder's motor vehicle insurance policy; temporary vehicle rental expenses; sales taxes and registration fees on a replacement vehicle that is at least the same year, make, and model of the stolen motor vehicle; and the difference between the benefits paid to the service agreement holder for the stolen vehicle under the service agreement holder's comprehensive coverage and the actual cost of a replacement vehicle that is at least the same year, make, and model of the stolen motor vehicle; or

b. Pay a preestablished flat amount to the service agreement holder.

Payments shall not duplicate any benefits or expenses paid to the service agreement holder by the insurer providing comprehensive coverage under a motor vehicle insurance policy covering the stolen motor vehicle; however, the payment of vehicle protection expenses at a preestablished flat amount of $5,000 or less does not duplicate any benefits or expenses payable under any comprehensive motor vehicle insurance policy; ~~or~~

(c) ~~1.~~ For repair or replacement of tires or wheels on a motor vehicle damaged as a result of encountering a road hazard;

(d) For removal of dents, dings, or creases on a motor

vehicle that may be repaired using the process of paintless dent removal without affecting the existing paint finish and without using replacement body panels or sanding, bonding, or painting;

(e) For replacement of a motor vehicle key or key fob if the key or key fob is inoperable, lost, or stolen; or

(f) For other services that may be approved by the Commissioner of Insurance Regulation consistent with this part ~~For the payment for paintless dent-removal services provided by a company whose primary business is providing such services~~.

~~2. "Paintless dent-removal" means the process of removing dents, dings, and creases, including hail damage, from a vehicle without affecting the existing paint finish, but does not include services that involve the replacement of vehicle body panels or sanding, bonding, or painting.~~

(14) "Road hazard" means a danger that is encountered while operating a motor vehicle. The term includes, but is not limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs, and composite scraps.

Section 2. This act shall take effect July 1, 2016.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Finance and Tax, *Vice Chair*
Appropriations Subcommittee on Health and Human Services
Communications, Energy, and Public Utilities
Community Affairs
Fiscal Policy
Regulated Industries

JOINT COMMITTEE:
Joint Legislative Auditing Committee, *Alternating Chair*

SENATOR JOSEPH ABRUZZO
Minority Whip
25th District

January 7th, 2016

The Honorable Lizbeth Benacquisto
326 Senate Office Building
404 S. Monroe Street
Tallahassee, FL 32399

Dear Chairwoman Benacquisto:

I respectfully request Senate Bill 1120, Motor Vehicle Service Agreement Companies, be considered for placement on the Banking and Insurance committee agenda. This piece of legislation authorizes coverage under motor vehicle service agreements for specific damages caused by road hazards, additional coverage for key-fobs, and other services approved by the Commissioner.

Please feel free to contact me if I can provide you with any additional information. Thank you in advance for your consideration.

Sincerely,

Joseph Abruzzo

Cc: James Knudson, *Staff Director*
Sheri Green, *Administrative Assistant*

REPLY TO:
❒ 12300 Forest Hill Boulevard, Suite 200, Wellington, Florida 33414-5785 (561) 791-4774 FAX: (888) 284-6495
❒ 110 Dr. Martin Luther King, Jr. Boulevard, Belle Glade, Florida 33430-3900 (561) 829-1410
❒ 222 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

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 1164
INTRODUCER:	Banking and Insurance Committee and Senator Legg
SUBJECT:	Firesafety
DATE:	January 27, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Fav/CS**
2.			CF	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1164 amends s. 429.41, F.S., relating to the uniform firesafety standards for assisted living facilities. The bill repeals reference to the utilization of fire code requirements that are more than 20 years old and allows for the utilization of the most current addition of the Life Safety Code adopted by the Office of the State Fire Marshal.

II. Present Situation:

Assisted Living Facilities

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[2] Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[3]

[1] Section 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[2] Section 429.02(16), F.S.
[3] Section 429.02(1), F.S.

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[4] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on a number of criteria.[5] If, as determined by the facility administrator or health care provider, a resident no longer meets the criteria for continued residency or the facility is unable to meet the resident's needs, the resident must be discharged in accordance with the Resident Bill of Rights.[6]

An ALF must have a standard license issued by the Agency for Health Care Administration under part I of ch. 429, F.S., and part II of ch. 408, F.S. Currently, there are 3,078 licensed ALF's in Florida.[7]

Firesafety

Section 429.41, F.S., requires the Office of the State Fire Marshal, in cooperation with the Department of Health, to promulgate rules and fire safety procedures to ensure the safety of residents living within an ALF community. In addition, the Office of the State Fire Marshal is likewise tasked with the responsibility of providing training and education to the employees of the Agency for Health Care Administration who are responsible for regulating ALF communities.

Currently, an ALF is required to use the National Fire Protection Association (NFPA) Life Safety Code from 1994 when establishing uniform fire safety standards, requirements, training and education curriculum that is taught. With the 1994 Life Safety Code in statute an ALF is prohibited from utilizing more recent codes that have been adopted. The 1994 code does not encompass the safety improvements that have been developed and adopted into the code over the past 20 years.

III. Effect of Proposed Changes:

The bill allows ALF communities to use the most current Life Safety Code adopted by the State Fire Marshal rather than being required to use the 1994 edition. Additionally, the current NFPA 101A (Guide on Alternative Approaches to Life Safety) is also adopted which provides the same level of protection through a different approach than what is currently required in the Life Safety Code. Such alternative approaches would still need to be approved by the local official having jurisdiction.

The bill also prohibits a utility from charging above the actual expense incurred by the utility as it relates to the installation and maintenance of automatic fire sprinkler systems installed at an ALF. The law currently restricts local government from charging above the actual expense for the same installation.[8]

[4] For specific minimum standards see Fla. Admin. Code R 58A-5.0182.
[5] Section 429.26, F.S., and Fla. Admin. Code R 58A-5.0181.
[6] s. 429.28, F.S.
[7] Agency for Health Care Administration, Florida Health Finder Search, facility/provider type: Assisted Living Facility and advanced search: Gold Seal Award Recipient, (search conducted Jan. 22, 2016), available at: http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx (last visited Jan. 22, 2016).
[8] s. 429.41(1)(a)2.g.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

ALF communities will be able to add improvements and other amenities that are allowed under the current Life Safety Code.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 429.41 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 26, 2016:

- Technical amendment restating lines 27-28 that the State Fire Marshal shall "establish" not "adopt" fire safety standards for ALF communities.

B. Amendments:

None.

901942

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment (with title amendment)

Delete lines 27 - 28
and insert:
facility. Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

901942

Delete line 3

and insert:

F.S.; requiring the State Fire Marshal to establish

By Senator Legg

17-01414A-16 20161164__

A bill to be entitled

An act relating to firesafety; amending s. 429.41, F.S.; requiring the State Fire Marshal to adopt uniform firesafety standards for assisted living facilities; revising provisions relating to the minimum standards that must be adopted by the Department of Elderly Affairs for firesafety in assisted living facilities; clarifying the fees a utility may charge for the installation and maintenance of an automatic fire sprinkler system; providing an effective date.

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

Section 1. Subsection (1) of section 429.41, Florida Statutes, is amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. The State Fire Marshal shall adopt uniform firesafety standards for assisted living facilities as specified in s. 633.206. The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and

17-01414A-16 20161164__

preferences of residents, the department, in consultation with the agency, the Department of Children and Families, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for and maintenance of facilities, not in conflict with chapter 553, relating to plumbing, heating, cooling, lighting, ventilation, living space, and other housing conditions, which will ensure the health, safety, and comfort of residents ~~and protection from fire hazard, including adequate provisions for fire alarm and other fire protection suitable to the size of the structure~~. ~~Uniform firesafety standards shall be established and enforced by the State Fire Marshal in cooperation with the agency, the department, and the Department of Health.~~

1. Firesafety evacuation capability determination.—

~~a. The National Fire Protection Association, NFPA 101A, Chapter 5, 1995 edition, shall be used for determining the ability of the residents, with or without staff assistance, to relocate from or within a licensed facility to a point of safety as provided in the fire codes adopted herein.~~ An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure. ~~For existing licensed facilities that are not equipped with an automatic fire sprinkler system, the administrator shall evaluate the evacuation capability of residents at least annually. The evacuation capability evaluation for each facility not equipped with an automatic fire sprinkler system shall be validated, without liability, by the State Fire Marshal, by the local fire~~

~~marshal, or by the local authority having jurisdiction over firesafety, before the license renewal date. If the State Fire Marshal, local fire marshal, or local authority having jurisdiction over firesafety has reason to believe that the evacuation capability of a facility as reported by the administrator may have changed, it may, with assistance from the facility administrator, reevaluate the evacuation capability through timed exiting drills. Translation of timed fire exiting drills to evacuation capability may be determined:~~

~~(I) Three minutes or less: prompt.~~

~~(II) More than 3 minutes, but not more than 13 minutes: slow.~~

~~(III) More than 13 minutes: impractical.~~

~~b. The Office of the State Fire Marshal shall provide or cause the provision of training and education on the proper application of Chapter 5, NFPA 101A, 1995 edition, to its employees, to staff of the Agency for Health Care Administration who are responsible for regulating facilities under this part, and to local governmental inspectors. The Office of the State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.~~

~~c. The Office of the State Fire Marshal, in cooperation with provider associations, shall provide or cause the provision of a training program designed to inform facility operators on how to properly review bid documents relating to the installation of automatic fire sprinklers. The Office of the~~

~~State Fire Marshal shall provide or cause the provision of this training within its existing budget, but may charge a fee for this training to offset its costs. The initial training must be delivered within 6 months after July 1, 1995, and as needed thereafter.~~

~~d. The administrator of a licensed facility shall sign an affidavit verifying the number of residents occupying the facility at the time of the evacuation capability evaluation.~~

2. Firesafety requirements.—

a. ~~Except for the special applications provided herein, effective January 1, 1996,~~ The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions ~~1994 edition~~, ~~Chapter 22 for new facilities and Chapter 23 for existing facilities~~ shall be used in determining the uniform firesafety ~~fire~~ code adopted ~~applied~~ by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.

~~b. Any new facility, regardless of size, that applies for a license on or after January 1, 1996, must be equipped with an automatic fire sprinkler system. The exceptions as provided in s. 22-2.3.5.1, NFPA 101, 1994 edition, as adopted herein, apply to any new facility housing eight or fewer residents. On July 1, 1995, local governmental entities responsible for the issuance of permits for construction shall inform, without liability, any facility whose permit for construction is obtained before January 1, 1996, of this automatic fire sprinkler requirement. As used in this part, the term "a new facility" does not mean an existing facility that has undergone change of ownership.~~

~~c. Notwithstanding any provision of s. 633.206 or of the National Fire Protection Association, NFPA 101A, Chapter 5, 1995~~

~~edition, to the contrary, any existing facility housing eight or fewer residents is not required to install an automatic fire sprinkler system, nor to comply with any other requirement in Chapter 23, NFPA 101, 1994 edition, that exceeds the firesafety requirements of NFPA 101, 1988 edition, that applies to this size facility, unless the facility has been classified as impractical to evacuate. Any existing facility housing eight or fewer residents that is classified as impractical to evacuate must install an automatic fire sprinkler system within the timeframes granted in this section.~~

~~d. Any existing facility that is required to install an automatic fire sprinkler system under this paragraph need not meet other firesafety requirements of Chapter 23, NFPA 101, 1994 edition, which exceed the provisions of NFPA 101, 1988 edition. The mandate contained in this paragraph which requires certain facilities to install an automatic fire sprinkler system supersedes any other requirement.~~

~~e. This paragraph does not supersede the exceptions granted in NFPA 101, 1988 edition or 1994 edition.~~

~~f. This paragraph does not exempt facilities from other firesafety provisions adopted under s. 633.206 and local building code requirements in effect before July 1, 1995.~~

b.~~g.~~ A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in an existing and properly licensed assisted living facility structure ~~as of January 1, 1996~~.

~~h. If a licensed facility undergoes major reconstruction or~~

~~addition to an existing building on or after January 1, 1996, the entire building must be equipped with an automatic fire sprinkler system. Major reconstruction of a building means repair or restoration that costs in excess of 50 percent of the value of the building as reported on the tax rolls, excluding land, before reconstruction. Multiple reconstruction projects within a 5-year period the total costs of which exceed 50 percent of the initial value of the building when the first reconstruction project was permitted are to be considered as major reconstruction. Application for a permit for an automatic fire sprinkler system is required upon application for a permit for a reconstruction project that creates costs that go over the 50 percent threshold.~~

~~i. Any facility licensed before January 1, 1996, that is required to install an automatic fire sprinkler system shall ensure that the installation is completed within the following timeframes based upon evacuation capability of the facility as determined under subparagraph 1.:~~

~~(I) Impractical evacuation capability, 24 months.~~

~~(II) Slow evacuation capability, 48 months.~~

~~(III) Prompt evacuation capability, 60 months.~~

~~The beginning date from which the deadline for the automatic fire sprinkler installation requirement must be calculated is upon receipt of written notice from the local fire official that an automatic fire sprinkler system must be installed. The local fire official shall send a copy of the document indicating the requirement of a fire sprinkler system to the Agency for Health Care Administration.~~

~~j. It is recognized that the installation of an automatic fire sprinkler system may create financial hardship for some facilities. The appropriate local fire official shall, without liability, grant two 1-year extensions to the timeframes for installation established herein, if an automatic fire sprinkler installation cost estimate and proof of denial from two financial institutions for a construction loan to install the automatic fire sprinkler system are submitted. However, for any facility with a class I or class II, or a history of uncorrected class III, firesafety deficiencies, an extension must not be granted. The local fire official shall send a copy of the document granting the time extension to the Agency for Health Care Administration.~~

~~k. A facility owner whose facility is required to be equipped with an automatic fire sprinkler system under Chapter 23, NFPA 101, 1994 edition, as adopted herein, must disclose to any potential buyer of the facility that an installation of an automatic fire sprinkler requirement exists. The sale of the facility does not alter the timeframe for the installation of the automatic fire sprinkler system.~~

~~l. Existing facilities required to install an automatic fire sprinkler system as a result of construction-type restrictions in Chapter 23, NFPA 101, 1994 edition, as adopted herein, or evacuation capability requirements shall be notified by the local fire official in writing of the automatic fire sprinkler requirement, as well as the appropriate date for final compliance as provided in this subparagraph. The local fire official shall send a copy of the document to the Agency for Health Care Administration.~~

~~m. Except in cases of life-threatening fire hazards, if an existing facility experiences a change in the evacuation capability, or if the local authority having jurisdiction identifies a construction-type restriction, such that an automatic fire sprinkler system is required, it shall be given time for installation as provided in this subparagraph.~~

~~Facilities that are fully sprinkled and in compliance with other firesafety standards are not required to conduct more than one of the required fire drills between the hours of 11 p.m. and 7 a.m., per year. In lieu of the remaining drills, staff responsible for residents during such hours may be required to participate in a mock drill that includes a review of evacuation procedures. Such standards must be included or referenced in the rules adopted by the State Fire Marshal. Pursuant to s. 633.206(1)(b), the State Fire Marshal is the final administrative authority for firesafety standards established and enforced pursuant to this section.~~

c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the department after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of

residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health.

(e) License application and license renewal, transfer of ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(f) Inspections, complaint investigations, moratoriums, classification of deficiencies, levying and enforcement of penalties, and use of income from fees and fines.

(g) The enforcement of the resident bill of rights specified in s. 429.28.

(h) The care and maintenance of residents, which must include, but is not limited to:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The arrangement for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication;

6. The nutritional needs of residents;

7. Resident records; and

8. Internal risk management and quality assurance.

(i) Facilities holding a limited nursing, extended congregate care, or limited mental health license.

(j) The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(k) The use of physical or chemical restraints. The use of physical restraints is limited to half-bed rails as prescribed and documented by the resident's physician with the consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(l) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills.

Section 2. This act shall take effect July 1, 2016.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Education Pre-K - 12, Chair
Ethics and Elections, Vice Chair
Appropriations Subcommittee on Education
Fiscal Policy
Government Oversight and Accountability
Higher Education

SENATOR JOHN LEGG
17th District

Legg.John.web@FLSenate.gov

January 12, 2016

The Honorable Lizbeth Benacquisto
Committee on Banking and Insurance, Chair
320 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

RE: SB 1164 - Firesafety

Dear Chair Benacquisto:

SB 1164: Firesafety has been referred to your committee. I respectfully request that it be placed on the Committee on Banking and Insurance Agenda, at your convenience. Your leadership and consideration are appreciated.

Sincerely,

John Legg
State Senator, District 17

cc: James Knudson, Staff Director
Sheri Green, Administrative Assistant

REPLY TO:
❒ 262 Crystal Grove Boulevard, Lutz, Florida 33548 (813) 909-9919
❒ 316 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5017

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-16
Meeting Date

SB 1164
Bill Number (if applicable)

Topic SB 1164

Amendment Barcode (if applicable)

Name Elizabeth Boyd

Job Title Legislative Director

Address 400 N. Monroe ST
Street

Phone 850 413 2863

Tallahassee FL 32399
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Dept. of Financial Services

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26-16
Meeting Date

SB 1164
Bill Number (if applicable)

Topic Firesafety

Amendment Barcode (if applicable)

Name Susan Anderson

Job Title VP Public Policy

Address 2583 Halleck Lane
Street

Phone 850-708-4971

Tallahassee FL 32312
City *State* *Zip*

Email sanderson@flalfa.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL ALFA

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/26/16
Meeting Date

SB 1164
Bill Number (if applicable)

Topic Fire Safety

Amendment Barcode (if applicable)

Name Gail Matillo (Mă-till-O)

Job Title President / CEO

Address 9445 Buck Haven Tr.
Street

Phone 850-496-2562

Tallahassee FL 32312
City *State* *Zip*

Email gmatillo@flalfa.org

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

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

Representing FL ALFA (FL Assisted Living Federation)

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

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

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

1164
Bill Number (if applicable)

Topic Firesafety

Amendment Barcode (if applicable)

Name Melody Arnold

Job Title Govt Affairs Mngr

Address 307 west park Ave
Street

Phone (850) 224-3907

TLH — FL — 32301
City — *State* — *Zip*

Email marnold@fhca.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Health Care Assoc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

SB 1164
Bill Number (if applicable)

Topic Firesafety

Amendment Barcode (if applicable)

Name Eric Prutsman

Job Title

Address P.O. Box 10448
Street
Tallahassee, FL 32302
City *State* *Zip*

Phone 850-894-6601

Email eric@prutsmanlaw.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Fire Marshals & Inspectors Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

SB 1164
Bill Number (if applicable)

Topic Firesafety

Amendment Barcode (if applicable)

Name Zayne Smith

Job Title ASD

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Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/15
Meeting Date

SB 1164
Bill Number (if applicable)

Topic AILS

Amendment Barcode (if applicable)

Name Buddy DeWar

Job Title

Address 5501 Touraine Dr.
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Tallahassee FL 32308
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Phone

Email GR8BudD@AOL.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Myself

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

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 1170
INTRODUCER:	Banking and Insurance Committee and Senator Detert
SUBJECT:	Health Plan Regulatory Administration
DATE:	January 27, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1170 revises provisions in the Insurance Code and other Florida Statutes that conflict with the federal Patient Protection and Affordable Care Act (PPACA) and provides other changes. These changes include:

- Eliminates provisions relating to preexisting condition exclusions since the federal act requires guaranteed issue of coverage and prohibits preexisting condition exclusions;
- Removes the requirement that insurers provide an outline of coverage for individual or family accident and health insurance policies. Instead, insurers are required to provide an outline of coverage for a large group policy or policy offering excepted benefits. The PPACA requires a summary of benefits be included in individual and small group major medical policies;
- Eliminates provisions relating to medical loss ratios since the federal act prescribes such standards and requires rebates if certain conditions are met;
- Eliminates the requirement for insurers to issue certificates of creditable coverage. Under current law, insurers are required to issue certificates of coverage to individuals switching health insurance plan that would allow the individual to use this credit to offset some preexisting condition exclusion period. Effective December 31, 2014, federal regulations no longer require the issuance of certificates of creditable coverage; and
- Provides technical and conforming changes.

The effective date of the bill is July 1, 2016.

II. Present Situation:

Federal Patient Protection and Affordable Care Act (PPACA)

The federal Patient Protection and Affordable Care Act was signed into law on March 23, 2010.[1] The federal law made significant changes to the U.S. health care system such as providing requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, establishing and reporting of medical loss ratios and payment of rebates, covering adult dependents, internal and external appeals of adverse benefit determinations, and other requirements on individual and group coverage.[2] All health insurance coverage sold in the individual and group market must include the benefits in the essential health benefits benchmark with some exceptions. Excepted benefits are not subject to these requirements.[3]

Generally, health insurance is divided into two types of coverage: major medical coverage and excepted benefits. The federal PPACA regulates major medical, or comprehensive health insurance. Health insurance that provides benefits on a limited or ancillary basis have been referred to as excepted benefits. The Florida Insurance Code delineates the excepted benefits in s. 627.6561(5)(b), F.S. Excepted benefits include coverage like limited scope dental, hospital indemnity, specified disease, etc.

Guaranteed Availability and Renewability of Coverage

Individual major medical health maintenance organization (HMO) coverage is guaranteed issue and renewable. That is, the PPACA requires health insurers to accept every individual and every employer that applies for coverage, commonly referred to as offering coverage on a guaranteed issue basis. The PPACA also requires health insurers to renew or continue in force the coverage with exceptions.[4] In Florida, this requirement is found in s. 627.6425(1), F.S., that applies to coverage defined in s. 627.6561(5)(a)2., F.S., which includes insurer policies and HMO contracts.

Grandfathered Health Plans

The PPACA exempts "grandfathered health plan coverage" from many of its insurance requirements (as specified in the summary of the key insurance provisions, below). For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule.[5] Grandfathered health plan coverage is tied to the individual

1 On March 23, 2010, President Obama signed into law Public Law No. 111-148, the Patient Protection and Affordable Care Act (PPACA), and on March 30, 2010, President Obama signed into law Public Law No. 111-152, the Health Care and Education Affordability Reconciliation Act of 2010, amending PPACA.

[2] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. 300gg et seq.).

[3] 42 U.S.C. s. 300gg-91.

[4] 45 C.F.R. s. 147.104 and 45 C.F.R. s. 147.106.

[5] PPACA s. 1251; 42 U.S.C. s. 18011 and 45 C.F.R. s. 147.140.

or employer who obtained the coverage, not to the policy or contract form itself. An insurer may have both policyholders with grandfathered coverage and policyholders with non-grandfathered coverage insured under the same policy form, depending on whether the coverage was effective before or after March 23, 2010. The conditions for maintaining grandfathered status are specified in the rule.

Medical Loss Ratio; Payment of Rebates

Effective for plan years beginning January 1, 2011, the PPACA requires health insurers to report to the federal Department of Health and Human Services information concerning the percent of premium revenue spent on claims for clinical services and activities (medical loss ratio or MLR). Insurers must provide a rebate to consumers if the MLR is less than 85 percent in the large group market and 80 percent in the small group and individual markets. [6] Grandfathered health plans are not exempt from this requirement. Florida law requires as a condition of prior approval of rates by the OIR, that the projected minimum loss ratio for small group and individual policies is 65 percent.[7] Rebates are not required if the MLR is not met. The calculation of Florida's MLR is not consistent with federal regulations.

Summary of Benefits and Coverage

The PPACA directs HHS and the Department of Treasury to develop standards for insurers and HMOs to use in compiling and providing a summary of benefits and coverage (SBC) that ''accurately describes the benefits and coverage under the applicable plan or coverage." On June 16, 2015, the U.S. Department of Health and Human Services issued final rules relating to the summary of benefits and coverage disclosures that insurers and HMOs are required to provide for individual and group coverage. Section 627.6482, F.S., requires insurers to provide an outline of coverage for individuals and family accident and health policies.

Preexisting Conditions and Certificates of Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[8] was enacted to provide guaranteed availability of coverage for certain employees and individuals, and to increase portability through the limitation of preexisting condition exclusions. Generally, group plans were allowed to impose a preexisting condition exclusion for up to 18 months after the enrollment date. The exclusion period could be reduced by the aggregate periods of creditable coverage applicable to the individual as of the enrollment date. Creditable coverage included group health plan and other specified coverage. Creditable coverage did not include excepted benefits. In 1997,[9] Florida adopted many of the requirements of HIPAA, which in part, is codified in s. 627.6561, F.S.

Insurers were required to issue certificates of creditable coverage to individuals switching from one health insurance plan that would allow the individual to mitigate or avoid preexisting condition exclusions. Effective December 31, 2014, certificates of creditable coverage are no longer required to be provided. After December 31, 2014, most health insurance plans will no

[6] 45 C.F.R. part 158.
[7] Section 627.411(3)(a), F.S.
[8] Pub.L. 104–191.
[9] Ch. 97-179, Laws of Fla.

longer contain preexisting condition exclusions because of the PPACA.[10]

Office of Insurance Regulation

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities.

Florida Kidcare Program

The Florida Kidcare Program[11] (Kidcare) was created in 1998 by the Florida Legislature in response to the federal enactment of the Children's Health Insurance Program (CHIP) in 1997. The Florida Kidcare program was created to provide a defined set of health benefits to uninsured, low-income children through the establishment of a variety of affordable health benefits coverage options from which families may select coverage and through which families may contribute financially to the health care of their children.[12]

III. Effect of Proposed Changes:

Section 1 amends s. 408.909, F.S., to revise a cross references to excepted benefits, limited benefit, which are amended in the bill.

Section 2 amends s. 409.817, F.S., relating to Kidcare, to eliminate an exception to the prohibition on preexisting condition exclusions, since PPACA prohibits such exclusions.

Sections 3 and 4 amends ss. 624.123 and 627.402, F.S., revise cross references to sections amended by the bill.

Section 5 deletes provisions within s. 627.411, F.S. The section removes a ground for disapproval of a major medical health insurance policy for failure to meet a 65 percent medical loss ratio and removing the definition of incurred claims. The PPACA requires major medical health insurance to have an 80 percent loss ratio. Since the PPACA requires insurers that write specific types of coverage to meet certain medical loss ratios, the only portion of this section that needs to be removed is subsection (3)(a). Removal of the whole section removes the definition of incurred claims under (3)(b), which the OIR indicates is needed to review the company's request for any rating action (increase or decrease).

Sections 6 and 7 amend ss. 627.6011 and 627.602, F.S. to update cross references to sections amended by the bill.

Section 8 amends s. 627.642, F.S., to eliminate the requirement that insurers provide an outline of coverage for individual or family accident and health insurance policies. Instead, insurers are required to provide an outline of coverage for a large group policy or policy offering excepted benefits. The PPACA requires a summary of benefits be included in individual and small group major medical policies.

[10] 45 C.F.R. 148.124.
[11] See http://floridakidcare.org/#eligible (last visited Jan. 23, 2016).
[12] Section 409.812, F.S.

Section 9 amends s. 627.6425, F.S., to remove the guaranteed renewable requirements for individual HMO major medical policies. Currently, s. 627.6425(1), F.S., applies to health insurance coverage as defined in s. 627.6561(5)(a)2., F.S., which includes HMO contracts. Additionally, the only guaranteed renewable statute in the HMO chapter is s. 641.31074, F.S., but it only applies to group health insurance. The bill deletes the s. 627.6561(5)(a)2., F.S., reference and refers to s. 624.603, F.S., the general section defining health insurance. Since the bill would delete s. 627.6561(5)(a)2., F.S., and since ch. 641, F.S., is part specific, individual HMO major medical insurance would be governed under the guaranteed renewable requirements in Rules 69O-149 and 69O-191, Florida Administrative Code. The PPACA requires guaranteed issuance and guaranteed renewability.

Section 10 amends s. 627.6487, F.S., to update cross references to sections amended by the bill.

Section 11 repeals s. 627.64871, F.S., which relates to creditable coverage and the issuance of certifications of coverage by insurers, since PPACA prohibits preexisting condition exclusions and such certificates are no longer required.

Section 12 amends s. 627.6512, F.S., relating to the exemption of certain policies from regulations imposed on health insurance policies, to update cross references to sections amended by the bill.

Section 13 amends s. 627.6513, F.S., to delineate excepted benefits and provide that excepted benefits do not apply to group policies.

Sections 14 and 21 repeal ss. 627.6561 and 641.31071, F.S., relating to relating to preexisting conditions and creditable coverage. The federal law prohibits insurers from excluding preexisting conditions and certificates of coverages are no longer required to be issued; so these provisions are unnecessary.

Section 15 amends s. 627.6562, F.S., relating to dependent coverage to provide a definition of creditable coverage, which delineates what type of coverage qualifies as "creditable coverage" and what coverage does not qualify as creditable. These provisions were delineated in s. 627.6561, F.S., that is being repealed by the bill.

Section 16 amends s. 727.65626, F.S., to update a cross reference to sections amended by the bill.

Section 17 amends s. 627.6699, F.S., to revise a cross reference to excepted benefits, which is amended by the bill. The section also provide a definition of "late enrollee," as provided in s. 627.6561(1)(b), F.S. The section eliminates provisions relating to preexisting condition exclusions.

Sections 18 and 19 amend ss. 627.6741 and 641.185, F.S., to update cross references to sections amended by the bill and eliminate a provision relating to preexisting conditions.

Section 20 amends s. 641.31, F.S. to delete current language, which exempts individual or large group HMO contracts from any law restricting or limiting deductibles, coinsurance, copayments

or annual or lifetime maximum payments. The federal law establishes deductibles, annual and lifetime limits and provides that copayments are not allowed for certain essential health benefits.

Sections 22 and 23 amends ss. 641.3111 and 641.312, F.S., relating to extension of benefits relating to conversion policies and update a cross reference to a section amended by the bill.

Section 24 provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The effective date of this bill is July 1, 2016. According to the OIR, implementing the changes proposed in this bill in the middle of a plan year may create policyholder confusion and market disruption. Making these provisions effective at the beginning of the calendar year could avoid these negative outcomes. [13]

C. Government Sector Impact:

Indeterminate. Not addressed in the OIR analysis.

VI. Technical Deficiencies:

Section 5 of the bill deletes 627.411(3)(a)and (b), F.S. According to the OIR, only subsection (3)(a) needs to be deleted. The removal of subsection (3)(b) removes the definition of incurred claims, which is needed to review the company's request for any rating action (increase or decrease and needs to be reinstated.[14]

[13] Office of Insurance Regulation, 2016 Agency Legislative Bill Analysis (Jan. 13, 2016) (on file with Banking and Insurance Committee).
[14] *Id.*

VII. Related Issues:

Section 22, which amends s. 641.3111, F.S., deletes a provision relating HMO extension of benefits.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 408.909, 409.817, 624.123, 627.402, 627.411, 627.6011, 627.602, 627.642, 627.6425, 627.6487, 627.6512, 627.6513, 627.6515, 627.6562, 627.65626, 627.6699, 627.6741, 641.185, 641.31, 641.3111, and 641.312.

This bill repeals the following sections of the Florida Statutes: 627.64871, 627.6561, 627.6675, and 641.31071.

IX. Additional Information:

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

CS by Banking and Insurance on January 26, 2016:
The CS reinstates provisions relating to HMO conversions and provides technical and conforming changes.

B. Amendments:

None.

724686

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Detert) recommended the following:

Senate Amendment (with title amendment)

Delete lines 206 - 215.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 21 - 22

and insert:

of eligibility; amending s. 627.6487, F.S.;

192718

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Detert) recommended the following:

Senate Amendment (with title amendment)

Delete lines 277 - 334.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete lines 24 - 29

and insert:

relating to certification of coverage; amending s.

747432

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Detert) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (d) of subsection (2) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

(2) DEFINITIONS.—As used in this section, the term:

(d) "Health care coverage" or "health flex plan coverage" means health care services that are covered as benefits under an

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approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis. The terms may also include one or more of the excepted benefits under s. 627.6513(1)-(13) ~~s. 627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered separately, or the benefits under s. 627.6561(5)(d), if offered as independent, noncoordinated benefits~~.

Section 2. Section 409.817, Florida Statutes, is amended to read:

409.817 Approval of health benefits coverage; financial assistance.—In order for health insurance coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage must:

(1) Be certified by the Office of Insurance Regulation of the Financial Services Commission under s. 409.818 as meeting, exceeding, or being actuarially equivalent to the benchmark benefit plan;

(2) Be guarantee issued;

(3) Be community rated;

(4) Not impose any preexisting condition exclusion for covered benefits; ~~however, group health insurance plans may permit the imposition of a preexisting condition exclusion, but only insofar as it is permitted under s. 627.6561;~~

(5) Comply with the applicable limitations on premiums and cost sharing in s. 409.816;

(6) Comply with the quality assurance and access standards developed under s. 409.820; and

(7) Establish periodic open enrollment periods, which may

not occur more frequently than quarterly.

Section 3. Paragraph (b) of subsection (1) of section 624.123, Florida Statutes, is amended to read:

624.123 Certain international health insurance policies; exemption from code.—

(1) International health insurance policies and applications may be solicited and sold in this state at any international airport to a resident of a foreign country. Such international health insurance policies shall be solicited and sold only by a licensed health insurance agent and underwritten only by an admitted insurer. For purposes of this subsection:

(b) "International health insurance policy" means health insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2. ~~s. 627.6561(5)(a)2.~~, which is offered to an individual, covering only a resident of a foreign country on an annual basis.

Section 4. Subsection (2) of section 627.402, Florida Statutes, is amended to read:

627.402 Definitions.—As used in this part, the term:

(2) "Nongrandfathered health plan" is a health insurance policy or health maintenance organization contract that is not a grandfathered health plan and does not provide the benefits or coverages specified under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(c)~~.

Section 5. Subsection (3) of section 627.411, Florida Statutes, is amended to read:

627.411 Grounds for disapproval.—

~~(3)(a) For health insurance coverage as described in s. 627.6561(5)(a)2., the minimum loss ratio standard of incurred claims to earned premium for the form shall be 65 percent.~~

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~~(b) Incurred claims are claims occurring within a fixed period, whether or not paid during the same period, under the terms of the policy period.~~

~~1. Claims include scheduled benefit payments or services provided by a provider or through a provider network for dental, vision, disability, and similar health benefits.~~

~~2. Claims do not include state assessments, taxes, company expenses, or any expense incurred by the company for the cost of adjusting and settling a claim, including the review, qualification, oversight, management, or monitoring of a claim or incentives or compensation to providers for other than the provisions of health care services.~~

~~3. A company may at its discretion include costs that are demonstrated to reduce claims, such as fraud intervention programs or case management costs, which are identified in each filing, are demonstrated to reduce claims costs, and do not result in increasing the experience period loss ratio by more than 5 percent.~~

~~4. For scheduled claim payments, such as disability income or long-term care, the incurred claims shall be the present value of the benefit payments discounted for continuance and interest.~~

Section 6. Section 627.6011, Florida Statutes, is amended to read:

627.6011 Mandated coverages.—Mandatory health benefits regulated under this chapter are not intended to apply to the types of health benefit plans listed in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(e)~~, issued in any market, unless specifically designated otherwise. For purposes of this section, the term

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"mandatory health benefits" means those benefits set forth in ss. 627.6401-627.64193, and any other mandatory treatment or health coverages or benefits enacted on or after July 1, 2012.

Section 7. Paragraph (h) of subsection (1) of section 627.602, Florida Statutes, is amended to read:

627.602 Scope, format of policy.—

(1) Each health insurance policy delivered or issued for delivery to any person in this state must comply with all applicable provisions of this code and all of the following requirements:

(h) Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances. This paragraph does not apply to a health insurance policy that is subject to the Subscriber Assistance Program under s. 408.7056 or to the types of benefits or coverages provided under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(c)~~ issued in any market.

Section 8. Subsection (1) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

(1) A policy offering benefits defined in s. 627.6513(1)-(14) or a large group ~~no individual or family accident and health insurance~~ policy may not ~~shall~~ be delivered, or issued for delivery, in this state unless:

(a) It is accompanied by an appropriate outline of coverage; or

(b) An appropriate outline of coverage is completed and delivered to the applicant at the time application is made, and an acknowledgment of receipt or certificate of delivery of such

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outline is provided to the insurer with the application.

In the case of a direct response, such as a written application to the insurance company from an applicant, the outline of coverage shall accompany the policy when issued.

Section 9. Subsections (1), (6), and (7) of section 627.6425, Florida Statutes, are amended, to read:

627.6425 Renewability of individual coverage.—

(1) Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. For the purpose of this section, the term "individual health insurance" means health insurance coverage, as described in s. 624.603 ~~s. 627.6561(5)(a)2.~~, offered to an individual in this state, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 627.6513(1)-(14) ~~subsection (6) or subsection (7)~~.

~~(6) The requirements of this section do not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(b).~~

~~(7) The requirements of this section do not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(c), (d), or (e), if the benefits are provided under a separate policy, certificate, or contract of insurance.~~

Section 10. Paragraph (b) of subsection (2) and subsection

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(3) of section 627.6487, Florida Statutes, are amended to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.—

(2) For the purposes of this section:

(b) "Individual health insurance" means health insurance, as defined in s. 624.603 ~~s. 627.6561(5)(a)2.~~, which is offered to an individual, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b) or, if the benefits are provided under a separate policy, certificate, or contract, the term does not include excepted benefits specified in s. 627.6561(5)(c), (d), or (e)~~.

(3) For the purposes of this section, the term "eligible individual" means an individual:

(a)1. For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6562(3) ~~s. 627.6561(5) and (6)~~, is 18 or more months; and

2.a. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan; or

b. Whose most recent prior creditable coverage was under an individual plan issued in this state by a health insurer or health maintenance organization, which coverage is terminated due to the insurer or health maintenance organization becoming insolvent or discontinuing the offering of all individual

coverage in the State of Florida, or due to the insured no longer living in the service area in the State of Florida of the insurer or health maintenance organization that provides coverage through a network plan in the State of Florida;

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured employer plan;

3. Part A or part B of Title XVIII of the Social Security Act; or

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) was not terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

(d) Who, having been offered the option of continuation coverage under a COBRA continuation provision or under s. 627.6692, elected such coverage; and

(e) Who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

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Section 11. Section 627.64871, Florida Statutes, is repealed.

Section 12. Section 627.6512, Florida Statutes, is amended to read:

627.6512 Exemption of certain group health insurance policies.—Sections ~~627.6561,~~ 627.65615, 627.65625, and 627.6571 do not apply to~~:~~

~~(1)~~ any group insurance policy in relation to its provision of ~~excepted~~ benefits described in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)~~.

~~(2) Any group health insurance policy in relation to its provision of excepted benefits described in s. 627.6561(5)(c), if the benefits:~~

~~(a) Are provided under a separate policy, certificate, or contract of insurance; or~~

~~(b) Are otherwise not an integral part of the policy.~~

~~(3) Any group health insurance policy in relation to its provision of excepted benefits described in s. 627.6561(5)(d), if all of the following conditions are met:~~

~~(a) The benefits are provided under a separate policy, certificate, or contract of insurance;~~

~~(b) There is no coordination between the provision of such benefits and any exclusion of benefits under any group policy maintained by the same policyholder; and~~

~~(c) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health policy maintained by the same policyholder.~~

~~(4) Any group health policy in relation to its provision of~~

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~~excepted benefits described in s. 627.6561(5)(c), if the benefits are provided under a separate policy, certificate, or contract of insurance.~~

Section 13. Section 627.6513, Florida Statutes, is amended to read:

627.6513 Scope.—Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances, apply to all group health insurance policies issued under this part. This section does not apply to a group health insurance policy that is subject to the Subscriber Assistance Program in s. 408.7056 or to: ~~the types of benefits or coverages provided under s. 627.6561(5)(b)-(c) issued in any market.~~

(1) Coverage only for accident insurance or disability income insurance, or any combination thereof.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical payment insurance.

(6) Credit-only insurance.

(7) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

(8) Other similar insurance coverage, specified in rules adopted by the commission, under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

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(9) Limited scope dental or vision benefits, if offered separately.

(10) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof, if offered separately.

(11) Other similar limited benefits, if offered separately, as specified in rules adopted by the commission.

(12) Coverage only for a specified disease or illness, if offered as independent, noncoordinated benefits.

(13) Hospital indemnity or other fixed indemnity insurance, if offered as independent, noncoordinated benefits.

(14) Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental coverage provided to coverage under a group health plan, which are offered as a separate insurance policy and as independent, noncoordinated benefits.

Section 14. Section 627.6561, Florida Statutes, is repealed.

Section 15. Subsection (3) of section 627.6562, Florida Statutes, is amended to read:

627.6562 Dependent coverage.—

(3) If, pursuant to subsection (2), a child is provided coverage under the parent’s policy after the end of the calendar year in which the child reaches age 25 and coverage for the child is subsequently terminated, the child is not eligible to be covered under the parent’s policy unless the child was continuously covered by other creditable coverage without a gap

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in coverage of more than 63 days.

(a) For the purposes of this subsection, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: ~~has the same meaning as provided in s. 627.6561(5).~~

1. A group health plan, as defined in s. 2791 of the Public Health Service Act.

2. Health insurance coverage consisting of medical care provided directly through insurance or reimbursement or otherwise, and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer.

3. Part A or part B of Title XVIII of the Social Security Act.

4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under s. 1928.

5. 10 U.S.C. chapter 55.

6. A medical care program of the Indian Health Service or of a tribal organization.

7. The Florida Comprehensive Health Association or another state health benefit risk pool.

8. A health plan offered under 5 U.S.C. chapter 89.

9. A public health plan as defined by rules adopted by the commission. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

10. A health benefit plan under s. 5(e) of the Peace Corps

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Act, 22 U.S.C. s. 2504(e).

(b) Creditable coverage does not include coverage that consists of one or more, or any combination thereof, of the following excepted benefits:

1. Coverage only for accident insurance or disability income insurance, or any combination thereof.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Workers' compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

7. Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

8. Other similar insurance coverage specified in rules adopted by the commission under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(c) The following benefits are not subject to the creditable coverage requirements, if offered separately:

1. Limited scope dental or vision benefits.

2. Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof.

3. Other similar, limited benefits specified in rules adopted by the commission.

(d) The following benefits are not subject to creditable

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coverage requirements if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness.

2. Hospital indemnity or other fixed indemnity insurance.

(e) Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental coverage provided to coverage under a group health plan are not considered creditable coverage if offered as a separate insurance policy.

Section 16. Subsection (1) of section 627.65626, Florida Statutes, is amended to read:

627.65626 Insurance rebates for healthy lifestyles.—

(1) Any rate, rating schedule, or rating manual for a health insurance policy that provides creditable coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~ filed with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan have enrolled and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan. The rebate may be based upon premiums paid in the last calendar year or policy year. The group must provide evidence of demonstrative maintenance or improvement of the enrollees' health status as determined by assessments of agreed-upon health status indicators between the policyholder and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. The group or health

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insurer may contract with a third-party administrator to assemble and report the health status required in this subsection between the policyholder and the health insurer. Any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equal or exceed the value of the rebate, but the rebate may not exceed 10 percent of paid premiums.

Section 17. Paragraphs (e), (l), and (n) of subsection (3), paragraphs (c) and (d) of subsection (5), and paragraph (b) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

(3) DEFINITIONS.—As used in this section, the term:

(e) "Creditable coverage" has the same meaning ascribed in s. 627.6562(3) ~~s. 627.6561~~.

(l) "Late enrollee" means an eligible employee or dependent who, with respect to coverage under a group health policy, is a participant or beneficiary who enrolls under the policy other than during:

1. The first period in which the individual is eligible to enroll under the policy.

2. A special enrollment period, as provided under s. 627.65615 ~~as defined under s. 627.6561(1)(b)~~.

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic

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area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows adjustments for~~:~~ claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5.

(5) AVAILABILITY OF COVERAGE.—

~~(c) Except as provided in paragraph (d), a health benefit plan covering small employers must comply with preexisting condition provisions specified in s. 627.6561 or, for health maintenance contracts, in s. 641.31071.~~

(c)~~(d)~~ A health benefit plan covering small employers, issued or renewed on or after January 1, 1994, must comply with the following conditions:

1. All health benefit plans must be offered and issued on a guaranteed-issue basis. Additional or increased benefits may only be offered by riders.

~~2. Paragraph (c) applies to health benefit plans issued to a small employer who has two or more eligible employees and to health benefit plans that are issued to a small employer who has fewer than two eligible employees and that cover an employee who has had creditable coverage continually to a date not more than 63 days before the effective date of the new coverage.~~

2.~~3.~~ For health benefit plans that are issued to a small employer who has fewer than two employees and that cover an employee who has not been continually covered by creditable coverage within 63 days before the effective date of the new coverage, preexisting condition provisions must not exclude coverage for a period beyond 24 months following the employee's effective date of coverage and may relate only to:

a. Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(b) For all small employer health benefit plans that are subject to this section and issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer is determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(e) ~~(5)(f)~~ and in which the premium may be adjusted as permitted by this paragraph. A small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to office review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may

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modify the rate one time within the 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the office that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. This subparagraph does not exempt an alliance or group association from licensure for activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health

status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, up to 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 4 percent for the current policy term, the carrier shall limit the application of such adjustments only to minus adjustments. For any subsequent policy term, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

6. A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent

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children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, the term "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

8. A carrier may separate the experience of small employer groups with fewer than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

a. If a carrier separates the experience of small employer groups, the rate to be charged to small employer groups of fewer than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained.

b. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees,

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insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

9. A carrier shall separate the experience of grandfathered health plans from nongrandfathered health plans for determining rates.

Section 18. Subsection (1) and paragraph (c) of subsection (2) of section 627.6741, Florida Statutes, are amended to read:

627.6741 Issuance, cancellation, nonrenewal, and replacement.—

(1)(a) An insurer issuing Medicare supplement policies in this state shall offer the opportunity of enrolling in a Medicare supplement policy, without conditioning the issuance or effectiveness of the policy on, and without discriminating in the price of the policy based on, the medical or health status or receipt of health care by the individual:

1. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of disability or end-stage renal disease, and who resides in this state, upon the request of the individual during the 6-month period beginning with the first month in which the individual has attained 65 years of age and is enrolled in Medicare Part B, or is eligible for Medicare by reason of a disability or end-stage renal disease, and is enrolled in Medicare Part B; or

2. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of a disability or end-stage renal disease, who is enrolled in Medicare Part B, and who resides in this state, upon the request

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of the individual during the 2-month period following termination of coverage under a group health insurance policy.

(b) The 6-month period to enroll in a Medicare supplement policy for an individual who is under 65 years of age and is eligible for Medicare by reason of disability or end-stage renal disease and otherwise eligible under subparagraph (a)1. or subparagraph (a)2. and first enrolled in Medicare Part B before October 1, 2009, begins on October 1, 2009.

(c) A company that has offered Medicare supplement policies to individuals under 65 years of age who are eligible for Medicare by reason of disability or end-stage renal disease before October 1, 2009, may, for one time only, effect a rate schedule change that redefines the age bands of the premium classes without activating the period of discontinuance required by s. 627.410(6)(e)2.

(d) As a part of an insurer’s rate filings, before and including the insurer’s first rate filing for a block of policy forms in 2015, notwithstanding the provisions of s. 627.410(6)(e)3., an insurer shall consider the experience of the policies or certificates for the premium classes including individuals under 65 years of age and eligible for Medicare by reason of disability or end-stage renal disease separately from the balance of the block so as not to affect the other premium classes. For filings in such time period only, credibility of that experience shall be as follows: if a block of policy forms has 1,250 or more policies or certificates in force in the age band including ages under 65 years of age, full or 100-percent credibility shall be given to the experience; and if fewer than 250 policies or certificates are in force, no or zero-percent

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credibility shall be given. Linear interpolation shall be used for in-force amounts between the low and high values. Florida-only experience shall be used if it is 100-percent credible. If Florida-only experience is not 100-percent credible, a combination of Florida-only and nationwide experience shall be used. If Florida-only experience is zero-percent credible, nationwide experience shall be used. The insurer may file its initial rates and any rate adjustment based upon the experience of these policies or certificates or based upon expected claim experience using experience data of the same company, other companies in the same or other states, or using data publicly available from the Centers for Medicaid and Medicare Services if the insurer's combined Florida and nationwide experience is not 100-percent credible, separate from the balance of all other Medicare supplement policies.

A Medicare supplement policy issued to an individual under subparagraph (a)1. or subparagraph (a)2. may not exclude benefits based on a preexisting condition if the individual has a continuous period of creditable coverage, as defined in s. 627.6562(3) ~~s. 627.6561(5)~~, of at least 6 months as of the date of application for coverage.

(2) For both individual and group Medicare supplement policies:

(c) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate or creditable coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods,

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and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy~~, subject to the requirements of s. 627.6561(6)-(11)~~.

Section 19. Paragraphs (f) and (h) of subsection (1) of section 641.185, Florida Statutes, are amended to read:

641.185 Health maintenance organization subscriber protections.—

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(f) A health maintenance organization subscriber should receive the flexibility to transfer to another Florida health maintenance organization, regardless of health status, pursuant to ss. 641.228, 641.3104, ~~641.3107,~~ 641.3111, 641.3921, and 641.3922.

(h) A health maintenance organization that issues a group health contract must~~: provide coverage for preexisting conditions pursuant to s. 641.31071;~~ guarantee renewability of coverage pursuant to s. 641.31074,~~;~~ provide notice of cancellation pursuant to s. 641.3108,~~;~~ provide extension of benefits pursuant to s. 641.3111,~~;~~ provide for conversion on termination of eligibility pursuant to s. 641.3921,~~;~~ and provide for conversion contracts and conditions pursuant to s. 641.3922.

Section 20. Subsection (2) and paragraph (a) of subsection

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(40) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.—

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. ~~A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract that provides coverage as described in s. 641.31071(5)(a)2., offered or delivered to an individual or a group of 51 or more persons.~~ The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(40)(a) Any group rate, rating schedule, or rating manual for a health maintenance organization policy, which provides creditable coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~, filed with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan are enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group contract holder. The group must provide evidence of demonstrative maintenance or improvement of his or her health status as determined by assessments of agreed-upon health status

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indicators between the group and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health maintenance organization is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equals or exceeds the value of the rebate but the rebate may not exceed 10 percent of paid premiums.

Section 21. Section 641.31071, Florida Statutes, is repealed.

Section 22. Subsection (4) of section 641.3111, Florida Statutes, is amended to read:

641.3111 Extension of benefits.—

~~(4) Except as provided in subsection (1), no subscriber is entitled to an extension of benefits if the termination of the contract by the health maintenance organization is based upon any event referred to in s. 641.3922(7)(a), (b), or (c).~~

Section 23. Section 641.312, Florida Statutes, is amended to read:

641.312 Scope.—The Office of Insurance Regulation may adopt rules to administer the provisions of the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act, issued by the National Association of Insurance Commissioners and dated April 2010. This section does not apply to a health maintenance contract that is subject to the Subscriber Assistance Program under s. 408.7056 or to the types of benefits or coverages provided under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(e)~~ issued in any market.

Section 24. This act shall take effect July 1, 2016.

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736
737 ================ T I T L E A M E N D M E N T ================
738 And the title is amended as follows:
739 Delete everything before the enacting clause
740 and insert:
741 A bill to be entitled
742 An act relating to health plan regulatory
743 administration; amending s. 408.909, F.S.; redefining
744 the term "health care coverage" or "health flex plan
745 coverage"; amending s. 409.817, F.S.; deleting a
746 provision authorizing group insurance plans to impose
747 a certain preexisting condition exclusion; amending s.
748 624.123, F.S.; conforming a cross-reference; amending
749 s. 627.402, F.S.; redefining the term
750 "nongrandfathered health plan"; amending s. 627.411,
751 F.S.; deleting a provision relating to a minimum loss
752 ratio standard for specified health insurance
753 coverage; deleting provisions specifying certain
754 incurred claims; amending s. 627.6011, F.S.,
755 conforming a cross-reference; amending s. 627.602,
756 F.S.; conforming a cross-reference; amending s.
757 627.642, F.S.; revising the policies to which certain
758 outline of coverage requirements apply; amending s.
759 627.6425, F.S.; redefining the term "individual health
760 insurance"; revising applicability; amending s.
761 627.6487, F.S.; redefining terms; repealing s.
762 627.64871, F.S., relating to certification of
763 coverage; amending s. 627.6512, F.S.; revising a
764 provision specifying that certain sections of the

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Florida Insurance Code do not apply to a group health insurance policy as that policy relates to specified benefits, under certain circumstances; amending s. 627.6513, F.S.; excluding applicability as to certain types of benefits or coverages; repealing s. 627.6561, F.S., relating to preexisting conditions; amending s. 627.6562, F.S.; redefining the term "creditable coverage"; providing exceptions and applicability; amending s. 627.65626, F.S.; conforming a cross-reference; amending s. 627.6699, F.S.; redefining terms; deleting a provision that requires a certain health benefit plan to comply with specified preexisting condition provisions; conforming provisions to changes made by the act; amending s. 627.6741, F.S.; conforming cross-references; conforming a provision to changes made by the act; amending s. 641.185, F.S.; revising certain standards to remove requirements for a health maintenance organization to provide specified coverage for preexisting conditions; conforming provisions to changes made by the act; amending s. 641.31, F.S.; deleting a provision specifying that a law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments may not apply to a certain health maintenance organization contract; conforming a cross-reference; repealing s. 641.31071, F.S., relating to preexisting conditions; amending s. 641.3111, F.S.; deleting a provision specifying that a subscriber is not entitled to an extension of benefits

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under certain circumstances after termination of a group health maintenance contract; amending s. 641.312, F.S.; conforming a cross-reference; providing an effective date.

By Senator Detert

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A bill to be entitled

An act relating to health plan regulatory administration; amending s. 408.909, F.S.; redefining the term "health care coverage" or "health flex plan coverage"; amending s. 409.817, F.S.; deleting a provision authorizing group insurance plans to impose a certain preexisting condition exclusion; amending s. 624.123, F.S.; conforming a cross-reference; amending s. 627.402, F.S.; redefining the term "nongrandfathered health plan"; amending s. 627.411, F.S.; deleting a provision relating to a minimum loss ratio standard for specified health insurance coverage; deleting provisions specifying certain incurred claims; repealing s. 627.6011, F.S., relating to mandated coverages; amending s. 627.602, F.S.; revising applicability; repealing s. 627.642, F.S., relating to outline of coverage; amending s. 627.6425, F.S.; redefining the term "individual health insurance"; revising applicability; repealing s. 627.646, F.S., relating to conversion on termination of eligibility; amending s. 627.6486, F.S.; conforming a cross-reference; amending s. 627.6487, F.S.; redefining terms; repealing s. 627.64871, F.S., relating to certification of coverage; amending s. 627.6488, F.S.; conforming cross-references; amending s. 627.6498, F.S.; deleting a requirement that the Office of Insurance Regulation establish certain standard risk rates for coverages issued by the Florida Comprehensive Health Association; amending s. 627.6512, F.S.; revising a provision specifying that certain sections of the Florida Insurance Code do not apply to a group health insurance policy as that

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policy relates to specified benefits, under certain circumstances; amending s. 627.6513, F.S.; excluding applicability as to certain types of benefits or coverages; amending s. 627.6515, F.S.; conforming a cross-reference; deleting a provision relating to a member's entitlement to certain rights and options after providing a specified notice of termination to an insurer; repealing s. 627.6561, F.S., relating to preexisting conditions; amending s. 627.6562, F.S.; redefining the term "creditable coverage"; providing exceptions and applicability; amending s. 627.65626, F.S.; conforming a cross-reference; repealing s. 627.6675, F.S., relating to conversion on termination of eligibility; amending s. 627.6699, F.S.; redefining terms; deleting a provision that requires a certain health benefit plan to comply with specified preexisting condition provisions; conforming provisions to changes made by the act; amending s. 627.6741, F.S.; conforming cross-references; conforming a provision to changes made by the act; amending s. 641.185, F.S.; revising certain standards to remove requirements for a health maintenance organization to provide specified coverage for preexisting conditions, provide specified conversion on termination of eligibility, and provide for specified conversion contracts and conditions; conforming provisions to changes made by the act; amending s. 641.31, F.S.; deleting a provision specifying that a law restricting or limiting

deductibles, coinsurance, copayments, or annual or lifetime maximum payments may not apply to a certain health maintenance organization contract; conforming a cross-reference; repealing s. 641.31071, F.S., relating to preexisting conditions; amending s. 641.3111, F.S.; deleting a provision specifying that a subscriber is not entitled to an extension of benefits under certain circumstances after termination of a group health maintenance contract; amending s. 641.312, F.S.; conforming a cross-reference; repealing s. 641.3921, F.S., relating to conversion on termination of eligibility; repealing s. 641.3922, F.S., relating to conversion contracts and conditions; providing an effective date.

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

Section 1. Paragraph (d) of subsection (2) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

(2) DEFINITIONS.—As used in this section, the term:

(d) "Health care coverage" or "health flex plan coverage" means health care services that are covered as benefits under an approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis. The terms may also include one or more of the excepted benefits under s. 627.6513(1)-(13) ~~s. 627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered separately, or the benefits under s. 627.6561(5)(d), if offered as independent, noncoordinated benefits~~.

Section 2. Section 409.817, Florida Statutes, is amended to read:

409.817 Approval of health benefits coverage; financial assistance.—In order for health insurance coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage must:

(1) Be certified by the Office of Insurance Regulation of the Financial Services Commission under s. 409.818 as meeting, exceeding, or being actuarially equivalent to the benchmark benefit plan;

(2) Be guarantee issued;

(3) Be community rated;

(4) Not impose any preexisting condition exclusion for covered benefits; ~~however, group health insurance plans may permit the imposition of a preexisting condition exclusion, but only insofar as it is permitted under s. 627.6561;~~

(5) Comply with the applicable limitations on premiums and cost sharing in s. 409.816;

(6) Comply with the quality assurance and access standards developed under s. 409.820; and

(7) Establish periodic open enrollment periods, which may not occur more frequently than quarterly.

Section 3. Paragraph (b) of subsection (1) of section 624.123, Florida Statutes, is amended to read:

624.123 Certain international health insurance policies; exemption from code.—

(1) International health insurance policies and

applications may be solicited and sold in this state at any international airport to a resident of a foreign country. Such international health insurance policies shall be solicited and sold only by a licensed health insurance agent and underwritten only by an admitted insurer. For purposes of this subsection:

(b) "International health insurance policy" means health insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2. ~~s. 627.6561(5)(a)2.~~, which is offered to an individual, covering only a resident of a foreign country on an annual basis.

Section 4. Subsection (2) of section 627.402, Florida Statutes, is amended to read:

627.402 Definitions.—As used in this part, the term:

(2) "Nongrandfathered health plan" is a health insurance policy or health maintenance organization contract that is not a grandfathered health plan and does not provide the benefits or coverages specified under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(c)~~.

Section 5. Subsection (3) of section 627.411, Florida Statutes, is amended to read:

627.411 Grounds for disapproval.—

~~(3)(a) For health insurance coverage as described in s. 627.6561(5)(a)2., the minimum loss ratio standard of incurred claims to earned premium for the form shall be 65 percent.~~

~~(b) Incurred claims are claims occurring within a fixed period, whether or not paid during the same period, under the terms of the policy period.~~

~~1. Claims include scheduled benefit payments or services provided by a provider or through a provider network for dental, vision, disability, and similar health benefits.~~

~~2. Claims do not include state assessments, taxes, company expenses, or any expense incurred by the company for the cost of adjusting and settling a claim, including the review, qualification, oversight, management, or monitoring of a claim or incentives or compensation to providers for other than the provisions of health care services.~~

~~3. A company may at its discretion include costs that are demonstrated to reduce claims, such as fraud intervention programs or case management costs, which are identified in each filing, are demonstrated to reduce claims costs, and do not result in increasing the experience period loss ratio by more than 5 percent.~~

~~4. For scheduled claim payments, such as disability income or long-term care, the incurred claims shall be the present value of the benefit payments discounted for continuance and interest.~~

Section 6. Section 627.6011, Florida Statutes, is repealed.

Section 7. Paragraph (h) of subsection (1) of section 627.602, Florida Statutes, is amended to read:

627.602 Scope, format of policy.—

(1) Each health insurance policy delivered or issued for delivery to any person in this state must comply with all applicable provisions of this code and all of the following requirements:

(h) Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances. This paragraph does not apply to a health insurance policy that is subject to the Subscriber Assistance Program under s. 408.7056

or to the types of benefits or coverages provided under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(c)~~ issued in any market.

Section 8. Section 627.642, Florida Statutes, is repealed.

Section 9. Subsections (1), (6), and (7) of section 627.6425, Florida Statutes, are amended, and present subsection (8) of that section is renumbered as subsection (6), to read:

627.6425 Renewability of individual coverage.—

(1) Except as otherwise provided in this section, an insurer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual. For the purpose of this section, the term "individual health insurance" means health insurance coverage, as described in s. 624.603 ~~s. 627.6561(5)(a)2.~~, offered to an individual in this state, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 627.6513(1)-(14) ~~subsection (6) or subsection (7)~~.

~~(6) The requirements of this section do not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(b).~~

~~(7) The requirements of this section do not apply to any health insurance coverage in relation to its provision of excepted benefits described in s. 627.6561(5)(c), (d), or (e), if the benefits are provided under a separate policy, certificate, or contract of insurance.~~

Section 10. Section 627.646, Florida Statutes, is repealed.

Section 11. Paragraph (h) of subsection (2) of section

627.6486, Florida Statutes, is amended to read:

627.6486 Eligibility.—

(2)

(h) All eligible persons who are classified as high-risk individuals pursuant to s. 627.6498(4)(a)3. ~~s. 627.6498(4)(a)4.~~ shall, upon application or renewal, agree to be placed in a case management system when it is determined by the board and the plan case manager that such system will be cost-effective and provide quality care to the individual.

Section 12. Paragraph (b) of subsection (2) and subsection (3) of section 627.6487, Florida Statutes, are amended to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.—

(2) For the purposes of this section:

(b) "Individual health insurance" means health insurance, as defined in s. 624.603 ~~s. 627.6561(5)(a)2.~~, which is offered to an individual, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b) or, if the benefits are provided under a separate policy, certificate, or contract, the term does not include excepted benefits specified in s. 627.6561(5)(c), (d), or (e)~~.

(3) For the purposes of this section, the term "eligible individual" means an individual:

(a)1. For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6562(3) ~~s.~~

~~627.6561(5) and (6)~~, is 18 or more months; and

2.a. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan; or

b. Whose most recent prior creditable coverage was under an individual plan issued in this state by a health insurer or health maintenance organization, which coverage is terminated due to the insurer or health maintenance organization becoming insolvent or discontinuing the offering of all individual coverage in the State of Florida, or due to the insured no longer living in the service area in the State of Florida of the insurer or health maintenance organization that provides coverage through a network plan in the State of Florida;

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

~~2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured employer plan;~~

2.~~3.~~ Part A or part B of Title XVIII of the Social Security Act; or

3.~~4.~~ A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) was not

terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

(d) Who, having been offered the option of continuation coverage under a COBRA continuation provision or under s. 627.6692, elected such coverage; and

(e) Who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

Section 13. Section 627.64871, Florida Statutes, is repealed.

Section 14. Paragraph (h) of subsection (4) of section 627.6488, Florida Statutes, is amended to read:

627.6488 Florida Comprehensive Health Association.—

(4) The association shall:

(h) Contract with preferred provider organizations and health maintenance organizations giving due consideration to the preferred provider organizations and health maintenance organizations which have contracted with the state group health insurance program pursuant to s. 110.123. If cost-effective and available in the county where the policyholder resides, the board, upon application or renewal of a policy, shall place a high-risk individual, as established under s. 627.6498(4)(a)3. ~~s. 627.6498(4)(a)4.~~, with the plan case manager who shall determine the most cost-effective quality care system or health care provider and shall place the individual in such system or with such health care provider. If cost-effective and available in the county where the policyholder resides, the board, with

the consent of the policyholder, may place a low-risk or medium-risk individual, as established under s. 627.6498(4)(a)3. ~~s. 627.6498(4)(a)4.~~, with the plan case manager who may determine the most cost-effective quality care system or health care provider and shall place the individual in such system or with such health care provider. Prior to and during the implementation of case management, the plan case manager shall obtain input from the policyholder, parent, or guardian.

Section 15. Paragraph (a) of subsection (4) of section 627.6498, Florida Statutes, is amended to read:

627.6498 Minimum benefits coverage; exclusions; premiums; deductibles.—

(4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.—

(a) The plan shall provide for annual deductibles for major medical expense coverage in the amount of $1,000 or any higher amounts proposed by the board and approved by the office, plus the benefits payable under any other type of insurance coverage or workers' compensation. The schedule of premiums and deductibles shall be established by the association. With regard to any preferred provider arrangement utilized by the association, the deductibles provided in this paragraph shall be the minimum deductibles applicable to the preferred providers and higher deductibles, as approved by the office, may be applied to providers who are not preferred providers.

1. Separate schedules of premium rates based on age may apply for individual risks.

2. Rates are subject to approval by the office.

~~3. Standard risk rates for coverages issued by the association shall be established by the office, pursuant to s. 627.6675(3).~~

3.~~4.~~ The board shall establish separate premium schedules for low-risk individuals, medium-risk individuals, and high-risk individuals and shall revise premium schedules annually beginning January 1999. No rate shall exceed 200 percent of the standard risk rate for low-risk individuals, 225 percent of the standard risk rate for medium-risk individuals, or 250 percent of the standard risk rate for high-risk individuals. For the purpose of determining what constitutes a low-risk individual, medium-risk individual, or high-risk individual, the board shall consider the anticipated claims payment for individuals based upon an individual's health condition.

Section 16. Section 627.6512, Florida Statutes, is amended to read:

627.6512 Exemption of certain group health insurance policies.—Sections ~~627.6561,~~ 627.65615, 627.65625, and 627.6571 do not apply to~~:~~

~~(1)~~ any group insurance policy in relation to its provision of ~~excepted~~ benefits described in s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)~~.

~~(2) Any group health insurance policy in relation to its provision of excepted benefits described in s. 627.6561(5)(c), if the benefits:~~

~~(a) Are provided under a separate policy, certificate, or contract of insurance; or~~

~~(b) Are otherwise not an integral part of the policy.~~

~~(3) Any group health insurance policy in relation to its provision of excepted benefits described in s. 627.6561(5)(d), if all of the following conditions are met:~~

~~(a) The benefits are provided under a separate policy, certificate, or contract of insurance;~~

~~(b) There is no coordination between the provision of such benefits and any exclusion of benefits under any group policy maintained by the same policyholder; and~~

~~(c) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health policy maintained by the same policyholder.~~

~~(4) Any group health policy in relation to its provision of excepted benefits described in s. 627.6561(5)(c), if the benefits are provided under a separate policy, certificate, or contract of insurance.~~

Section 17. Section 627.6513, Florida Statutes, is amended to read:

627.6513 Scope.—Section 641.312 and the provisions of the Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. s. 2560.503-1, relating to internal grievances, apply to all group health insurance policies issued under this part. This section does not apply to a group health insurance policy that is subject to the Subscriber Assistance Program in s. 408.7056 or to: ~~the types of benefits or coverages provided under s. 627.6561(5)(b)-(c) issued in any market.~~

(1) Coverage only for accident insurance or disability income insurance, or any combination thereof.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical payment insurance.

(6) Credit-only insurance.

(7) Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

(8) Other similar insurance coverage, specified in rules adopted by the commission, under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(9) Limited scope dental or vision benefits, if offered separately.

(10) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof, if offered separately.

(11) Other similar limited benefits, if offered separately, as specified in rules adopted by the commission.

(12) Coverage only for a specified disease or illness, if offered as independent, noncoordinated benefits.

(13) Hospital indemnity or other fixed indemnity insurance, if offered as independent, noncoordinated benefits.

(14) Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental coverage provided to coverage under a group health plan, which are offered as a separate insurance policy and as independent, noncoordinated benefits.

Section 18. Subsections (2) and (9) of section 627.6515,

Florida Statutes, are amended to read:

627.6515 Out-of-state groups.—

(2) Except as otherwise provided in this part, this part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if:

(a) The policy is issued to an employee group the composition of which is substantially as described in s. 627.653; a labor union group or association group the composition of which is substantially as described in s. 627.654; an additional group the composition of which is substantially as described in s. 627.656; a group insured under a blanket health policy when the composition of the group is substantially in compliance with s. 627.659; a group insured under a franchise health policy when the composition of the group is substantially in compliance with s. 627.663; an association group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance; a group that is established primarily for the purpose of providing group insurance, provided the benefits are reasonable in relation to the premiums charged thereunder and the issuance of the group policy has resulted, or will result, in economies of administration; or a group of insurance agents of an insurer, which insurer is the policyholder;

(b) Certificates evidencing coverage under the policy are issued to residents of this state and contain in contrasting color and not less than 10-point type the following statement: "The benefits of the policy providing your coverage are governed

primarily by the law of a state other than Florida"; and

(c) The policy provides the benefits specified in ss. 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121, 627.66122, 627.6613, 627.667, ~~627.6675,~~ 627.6691, and 627.66911~~,~~ and complies with the requirements of s. 627.66996.

(d) Applications for certificates of coverage offered to residents of this state must contain, in contrasting color and not less than 12-point type, the following statement on the same page as the applicant's signature:

"This policy is primarily governed by the laws of ...insert state where the master policy is filed.... As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services."

This paragraph applies only to group certificates providing health insurance coverage which require individualized underwriting to determine coverage eligibility for an individual or premium rates to be charged to an individual except for the following:

1. Policies issued to provide coverage to groups of persons all of whom are in the same or functionally related licensed professions, and providing coverage only to such licensed professionals, their employees, or their dependents;

2. Policies providing coverage to small employers as defined by s. 627.6699. Such policies shall be subject to, and governed by, the provisions of s. 627.6699;

3. Policies issued to a bona fide association, as defined by s. 627.6571(5), provided that there is a person or board acting as a fiduciary for the benefit of the members, and such association is not owned, controlled by, or otherwise associated with the insurance company; or

4. Any accidental death, accidental death and dismemberment, accident-only, vision-only, dental-only, hospital indemnity-only, hospital accident-only, cancer, specified disease, Medicare supplement, products that supplement Medicare, long-term care, or disability income insurance, or similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan, coinsurance, or deductibles or coverage issued as a supplement to workers' compensation or similar insurance, or automobile medical-payment insurance.

(9) Any insured shall be able to terminate membership or affiliation with the group to whom the master policy is issued. An insured that elects to terminate his or her membership or affiliation with the group shall provide written notice to the insurer. ~~Upon providing the written notice, the member shall be entitled to the rights and options provided by s. 627.6675.~~

Section 19. Section 627.6561, Florida Statutes, is repealed.

Section 20. Subsection (3) of section 627.6562, Florida Statutes, is amended to read:

627.6562 Dependent coverage.—

(3) If, pursuant to subsection (2), a child is provided coverage under the parent's policy after the end of the calendar year in which the child reaches age 25 and coverage for the child is subsequently terminated, the child is not eligible to be covered under the parent's policy unless the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days.

(a) For the purposes of this subsection, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following: ~~has the same meaning as provided in s. 627.6561(5).~~

1. A group health plan, as defined in s. 2791 of the Public Health Service Act.

2. Health insurance coverage consisting of medical care provided directly through insurance or reimbursement or otherwise, and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issuer.

3. Part A or part B of Title XVIII of the Social Security Act.

4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under s. 1928.

5. 10 U.S.C. chapter 55.

6. A medical care program of the Indian Health Service or of a tribal organization.

7. The Florida Comprehensive Health Association or another state health benefit risk pool.

8. A health plan offered under 5 U.S.C. chapter 89.

9. A public health plan as defined by rules adopted by the commission. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

10. A health benefit plan under s. 5(e) of the Peace Corps Act, 22 U.S.C. s. 2504(e).

(b) Creditable coverage does not include coverage that consists of one or more, or any combination thereof, of the following excepted benefits:

1. Coverage only for accident insurance or disability income insurance, or any combination thereof.

2. Coverage issued as a supplement to liability insurance.

3. Liability insurance, including general liability insurance and automobile liability insurance.

4. Workers' compensation or similar insurance.

5. Automobile medical payment insurance.

6. Credit-only insurance.

7. Coverage for onsite medical clinics, including prepaid health clinics under part II of chapter 641.

8. Other similar insurance coverage specified in rules adopted by the commission under which benefits for medical care are secondary or incidental to other insurance benefits. To the extent possible, such rules must be consistent with regulations

adopted by the United States Department of Health and Human Services.

(c) The following benefits are not subject to the creditable coverage requirements, if offered separately:

1. Limited scope dental or vision benefits.

2. Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination thereof.

3. Other similar, limited benefits specified in rules adopted by the commission.

(d) The following benefits are not subject to creditable coverage requirements if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness.

2. Hospital indemnity or other fixed indemnity insurance.

(e) Benefits provided through a Medicare supplemental health insurance policy, as defined under s. 1882(g)(1) of the Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55, and similar supplemental coverage provided to coverage under a group health plan are not considered creditable coverage if offered as a separate insurance policy.

Section 21. Subsection (1) of section 627.65626, Florida Statutes, is amended to read:

627.65626 Insurance rebates for healthy lifestyles.—

(1) Any rate, rating schedule, or rating manual for a health insurance policy that provides creditable coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~ filed with the office shall provide for an appropriate rebate of premiums paid in the

last policy year, contract year, or calendar year when the majority of members of a health plan have enrolled and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder and health plan. The rebate may be based upon premiums paid in the last calendar year or policy year. The group must provide evidence of demonstrative maintenance or improvement of the enrollees' health status as determined by assessments of agreed-upon health status indicators between the policyholder and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. The group or health insurer may contract with a third-party administrator to assemble and report the health status required in this subsection between the policyholder and the health insurer. Any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equal or exceed the value of the rebate, but the rebate may not exceed 10 percent of paid premiums.

Section 22. Section 627.6675, Florida Statutes, is repealed.

Section 23. Paragraphs (e), (l), and (n) of subsection (3), paragraphs (c) and (d) of subsection (5), and paragraph (b) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

(3) DEFINITIONS.—As used in this section, the term:

(e) "Creditable coverage" has the same meaning ascribed in

s. 627.6562(3) ~~s. 627.6561~~.

(l) "Late enrollee" means an eligible employee or dependent who, with respect to coverage under a group health policy, is a participant or beneficiary who enrolls under the policy other than during:

1. The first period in which the individual is eligible to enroll under the policy.

2. A special enrollment period, as provided under s. 627.65615 ~~as defined under s. 627.6561(1)(b)~~.

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows adjustments for: claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5.

(5) AVAILABILITY OF COVERAGE.—

~~(c) Except as provided in paragraph (d), a health benefit plan covering small employers must comply with preexisting condition provisions specified in s. 627.6561 or, for health maintenance contracts, in s. 641.31071.~~

(c)~~(d)~~ A health benefit plan covering small employers, issued or renewed on or after January 1, 1994, must comply with the following conditions:

1. All health benefit plans must be offered and issued on a guaranteed-issue basis. Additional or increased benefits may only be offered by riders.

~~2. Paragraph (c) applies to health benefit plans issued to a small employer who has two or more eligible employees and to health benefit plans that are issued to a small employer who has fewer than two eligible employees and that cover an employee who has had creditable coverage continually to a date not more than 63 days before the effective date of the new coverage.~~

2.~~3.~~ For health benefit plans that are issued to a small employer who has fewer than two employees and that cover an employee who has not been continually covered by creditable coverage within 63 days before the effective date of the new coverage, preexisting condition provisions must not exclude coverage for a period beyond 24 months following the employee's effective date of coverage and may relate only to:

a. Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(b) For all small employer health benefit plans that are subject to this section and issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer is determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco

use, or geographic area as determined under paragraph (5)(e) ~~(5)(f)~~ and in which the premium may be adjusted as permitted by this paragraph. A small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to office review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time within the 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the office that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are

approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. This subparagraph does not exempt an alliance or group association from licensure for activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, up to 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 4 percent for the current policy term, the carrier shall limit the application of such adjustments only to minus adjustments. For any subsequent policy term, if the total aggregate adjusted premium actually

charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

6. A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, the term "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

8. A carrier may separate the experience of small employer groups with fewer than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

a. If a carrier separates the experience of small employer groups, the rate to be charged to small employer groups of fewer than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained.

b. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

9. A carrier shall separate the experience of grandfathered health plans from nongrandfathered health plans for determining rates.

Section 24. Subsection (1) and paragraph (c) of subsection (2) of section 627.6741, Florida Statutes, are amended to read:

627.6741 Issuance, cancellation, nonrenewal, and replacement.—

(1)(a) An insurer issuing Medicare supplement policies in this state shall offer the opportunity of enrolling in a Medicare supplement policy, without conditioning the issuance or effectiveness of the policy on, and without discriminating in the price of the policy based on, the medical or health status

or receipt of health care by the individual:

1. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of disability or end-stage renal disease, and who resides in this state, upon the request of the individual during the 6-month period beginning with the first month in which the individual has attained 65 years of age and is enrolled in Medicare Part B, or is eligible for Medicare by reason of a disability or end-stage renal disease, and is enrolled in Medicare Part B; or

2. To any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of a disability or end-stage renal disease, who is enrolled in Medicare Part B, and who resides in this state, upon the request of the individual during the 2-month period following termination of coverage under a group health insurance policy.

(b) The 6-month period to enroll in a Medicare supplement policy for an individual who is under 65 years of age and is eligible for Medicare by reason of disability or end-stage renal disease and otherwise eligible under subparagraph (a)1. or subparagraph (a)2. and first enrolled in Medicare Part B before October 1, 2009, begins on October 1, 2009.

(c) A company that has offered Medicare supplement policies to individuals under 65 years of age who are eligible for Medicare by reason of disability or end-stage renal disease before October 1, 2009, may, for one time only, effect a rate schedule change that redefines the age bands of the premium classes without activating the period of discontinuance required by s. 627.410(6)(e)2.

(d) As a part of an insurer’s rate filings, before and

including the insurer's first rate filing for a block of policy forms in 2015, notwithstanding the provisions of s. 627.410(6)(e)3., an insurer shall consider the experience of the policies or certificates for the premium classes including individuals under 65 years of age and eligible for Medicare by reason of disability or end-stage renal disease separately from the balance of the block so as not to affect the other premium classes. For filings in such time period only, credibility of that experience shall be as follows: if a block of policy forms has 1,250 or more policies or certificates in force in the age band including ages under 65 years of age, full or 100-percent credibility shall be given to the experience; and if fewer than 250 policies or certificates are in force, no or zero-percent credibility shall be given. Linear interpolation shall be used for in-force amounts between the low and high values. Florida-only experience shall be used if it is 100-percent credible. If Florida-only experience is not 100-percent credible, a combination of Florida-only and nationwide experience shall be used. If Florida-only experience is zero-percent credible, nationwide experience shall be used. The insurer may file its initial rates and any rate adjustment based upon the experience of these policies or certificates or based upon expected claim experience using experience data of the same company, other companies in the same or other states, or using data publicly available from the Centers for Medicaid and Medicare Services if the insurer's combined Florida and nationwide experience is not 100-percent credible, separate from the balance of all other Medicare supplement policies.

A Medicare supplement policy issued to an individual under subparagraph (a)1. or subparagraph (a)2. may not exclude benefits based on a preexisting condition if the individual has a continuous period of creditable coverage, as defined in s. 627.6562(3) ~~s. 627.6561(5)~~, of at least 6 months as of the date of application for coverage.

(2) For both individual and group Medicare supplement policies:

(c) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate or creditable coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original policy~~, subject to the requirements of s. 627.6561(6)-(11)~~.

Section 25. Paragraphs (f) and (h) of subsection (1) of section 641.185, Florida Statutes, are amended to read:

641.185 Health maintenance organization subscriber protections.—

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(f) A health maintenance organization subscriber should

receive the flexibility to transfer to another Florida health maintenance organization, regardless of health status, pursuant to ss. 641.228, 641.3104, and ~~641.3107,~~ 641.3111~~, 641.3921, and 641.3922~~.

(h) A health maintenance organization that issues a group health contract must~~: provide coverage for preexisting conditions pursuant to s. 641.31071;~~ guarantee renewability of coverage pursuant to s. 641.31074~~,~~ ~~;~~ provide notice of cancellation pursuant to s. 641.3108, and~~;~~ provide extension of benefits pursuant to s. 641.3111~~; provide for conversion on termination of eligibility pursuant to s. 641.3921; and provide for conversion contracts and conditions pursuant to s. 641.3922~~.

Section 26. Subsection (2) and paragraph (a) of subsection (40) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.—

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. ~~A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract that provides coverage as described in s. 641.31071(5)(a)2., offered or delivered to an individual or a group of 51 or more persons.~~ The commission, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to

determine that a rate or proposed rate meets the requirements of this subsection.

(40)(a) Any group rate, rating schedule, or rating manual for a health maintenance organization policy, which provides creditable coverage as defined in s. 627.6562(3) ~~s. 627.6561(5)~~, filed with the office shall provide for an appropriate rebate of premiums paid in the last policy year, contract year, or calendar year when the majority of members of a health plan are enrolled in and have maintained participation in any health wellness, maintenance, or improvement program offered by the group contract holder. The group must provide evidence of demonstrative maintenance or improvement of his or her health status as determined by assessments of agreed-upon health status indicators between the group and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health maintenance organization is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equals or exceeds the value of the rebate but the rebate may not exceed 10 percent of paid premiums.

Section 27. Section 641.31071, Florida Statutes, is repealed.

Section 28. Subsection (4) of section 641.3111, Florida Statutes, is amended to read:

641.3111 Extension of benefits.—

~~(4) Except as provided in subsection (1), no subscriber is entitled to an extension of benefits if the termination of the contract by the health maintenance organization is based upon~~

~~any event referred to in s. 641.3922(7)(a), (b), or (c).~~

Section 29. Section 641.312, Florida Statutes, is amended to read:

641.312 Scope.—The Office of Insurance Regulation may adopt rules to administer the provisions of the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act, issued by the National Association of Insurance Commissioners and dated April 2010. This section does not apply to a health maintenance contract that is subject to the Subscriber Assistance Program under s. 408.7056 or to the types of benefits or coverages provided under s. 627.6513(1)-(14) ~~s. 627.6561(5)(b)-(e)~~ issued in any market.

Section 30. Section 641.3921, Florida Statutes, is repealed.

Section 31. Section 641.3922, Florida Statutes, is repealed.

Section 32. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 13, 2016

I respectfully request that **Senate Bill #1170**, relating to Heatlh Plan Regulatory Administration, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Nancy C. Detert
Florida Senate, District 28

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

1170
Bill Number (if applicable)

Topic Regulatory Modernization Bill

Amendment Barcode (if applicable)

Name Audrey Brown

Job Title President + C.E.O

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Street

Phone 850-386-2904

Tallahassee FL 32301
City *State* *Zip*

Email Audrey@FAHP.net

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

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

Representing Florida Association of Health Plans

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

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

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1386
INTRODUCER:	Banking and Insurance Committee and Senator Richter
SUBJECT:	Life Insurers
DATE:	January 27, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Fav/CS**
2.			CM	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1386 increases the maximum coverage limit for a preneed life insurance policy sold by a licensed life agent, funeral director, a direct depositor or employee of an authorized funeral establishment. Currently, the coverage limit may not exceed $12,500, plus an annual percentage increase based on the Department of Labor's Annual Consumer Price Index (CPI), beginning with the 2003 CPI. The bill increases the coverage limit to $21,000 plus an annual increase based on the CPI, beginning with the 2016 CPI.

The bill is effective upon becoming a law.

II. Present Situation:

Part III of chapter 626, F.S., provides for the regulation of life insurance agents. Under s. 626.785, F.S., a licensed agent on behalf of a funeral establishment or a funeral director, a funeral director, a direct disposer, or an employee of a funeral establishment that holds a certificate of authority pursuant to s. 497.452, F.S.,[1] may obtain an agent's license to sell only policies of life insurance covering the expense of a prearrangement for funeral services or merchandise so as to provide funds at the time the services and merchandise are needed. Such policies are referred to as preneed contracts.

[1] Chapter 497, F.S., entitled the Florida Funeral, Cemetery, and Consumer Services Act, provides for the regulatory oversight of the death care industry. The Act is administered jointly by the Division of Funeral, Cemetery, and Consumer Services of the Department of Financial Services and the Board of Funeral, Cemetery and Funeral Services.

A preneed contract is any arrangement or method of which the provider of funeral merchandise or service has actual knowledge, whereby any person agrees to sell burial merchandise or burial service in advance. Examples of "burial merchandise" are caskets, outer burial containers, urns, monuments, floral arrangements, and register books, and "burial service" includes any service offered or provided in connection with the final disposition, memorialization, interment, entombment, inurnment, or other disposition of human remains or cremated remains.

The face amount of insurance covered by any such policy may not exceed $12,500 plus an annual percentage increase based on the Annual Consumer Price Index compiled by the United States Department of Labor, beginning with the Annual Consumer Price Index announced by the United States Department of Labor for 2003. When taking into account the consumer price index from 2003 through 2015 the current cap for a preneed contract is $16,105.06[2]

III. Effect of Proposed Changes:

The bill increases the maximum coverage limit for a preneed life insurance policy sold by an agent, funeral director, a direct depositor or employee of a funeral establishment. Currently, the coverage limit may not exceed $12,500, plus an annual percentage increase based on the Department of Labor's Annual Consumer Price Index, beginning with the 2003 index. The bill increases the coverage limit to $21,000 plus an annual increase based on the Consumer Price Index announced by the United States Department of Labor, beginning with the 2016 version of the Index.

The bill is effective upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[2] Email received from the Office of Insurance Regulation (Jan 24, 2016) (On file with the Senate Committee on Banking and Insurance).

B. Private Sector Impact:

The public will be able to purchase a larger preneed contract to cover the costs of funeral services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 626.785 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 26, 2016:

- Replaces the limit of $22,500 with $21,000 and also includes this new limit in subsection (1)(d).
- Changes the CPI date from 2003 to 2016.

B. Amendments:

None.

709918

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Richter) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (d) of subsection (1) and subsection (3) of section 626.785, Florida Statutes, are amended to read:

626.785 Qualifications for license.—

(1) The department shall not grant or issue a license as life agent to any individual found by it to be untrustworthy or incompetent, or who does not meet the following qualifications:

709918

(d) Must not be a funeral director or direct disposer, or an employee or representative thereof, or have an office in, or in connection with, a funeral establishment, except that a funeral establishment may contract with a life insurance agent to sell a preneed contract as defined in s. 497.005. Notwithstanding other provisions of this chapter, such insurance agent may sell limited policies of insurance covering the expense of final disposition or burial of an insured in the amount of $21,000 ~~$12,500~~, plus an annual percentage increase based on the Annual Consumer Price Index compiled by the United States Department of Labor, beginning with the Annual Consumer Price Index announced by the United States Department of Labor for the year 2016 ~~2003~~.

(3) Notwithstanding any other provisions of this chapter, a funeral director, a direct disposer, or an employee of a funeral establishment that holds a certificate of authority pursuant to s. 497.452 may obtain an agent's license to sell only policies of life insurance covering the expense of a prearrangement for funeral services or merchandise so as to provide funds at the time the services and merchandise are needed. The face amount of insurance covered by any such policy shall not exceed $21,000 ~~$12,500~~, plus an annual percentage increase based on the Annual Consumer Price Index compiled by the United States Department of Labor, beginning with the Annual Consumer Price Index announced by the United States Department of Labor for 2016 ~~2003~~.

Section 2. This act shall take effect upon becoming a law.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

709918

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to life insurers; amending s. 626.785, F.S.; revising amounts of coverage of certain life insurance policies that may be sold by specified persons; revising the version of the Annual Consumer Price Index used as a basis for calculating certain annual percentage increases in specified policies; providing an effective date.

By Senator Richter

23-01511-16 20161386__

A bill to be entitled

An act relating to life insurers; amending s. 626.785, F.S.; revising the maximum limit of coverage of a specified life insurance policy that may be sold by a funeral director, a direct disposer, or an employee of a funeral establishment under certain circumstances; providing an effective date.

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

Section 1. Subsection (3) of section 626.785, Florida Statutes, is amended to read:

626.785 Qualifications for license.—

(3) Notwithstanding any other provisions of this chapter, a funeral director, a direct disposer, or an employee of a funeral establishment that holds a certificate of authority pursuant to s. 497.452 may obtain an agent's license to sell only policies of life insurance covering the expense of a prearrangement for funeral services or merchandise so as to provide funds at the time the services and merchandise are needed. The face amount of insurance covered by any such policy shall not exceed $22,500 ~~$12,500~~, plus an annual percentage increase based on the Annual Consumer Price Index compiled by the United States Department of Labor, beginning with the Annual Consumer Price Index announced by the United States Department of Labor for 2003.

Section 2. This act shall take effect upon becoming a law.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Ethics and Elections, *Chair*
Banking and Insurance, *Vice Chair*
Appropriations
Appropriations Subcommittee on Health and Human Services
Commerce and Tourism
Regulated Industries
Rules

SENATOR GARRETT RICHTER
President Pro Tempore
23rd District

January 14, 2016

The Honorable Lizbeth Benacquisto, Chair
Senate Committee on Banking and Insurance
320 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

Dear Chairman Benacquisto:

Senate Bill 1386, relating to Life Insurers, has been referred to the Committee on Banking and Insurance. I would appreciate the placing of this bill on the committee's agenda at your earliest convenience.

Thank you for your consideration.

Sincerely,

Garrett Richter

cc: James Knudson, Staff Director

REPLY TO:
❒ 3299 E. Tamiami Trail, Suite 203, Naples, Florida 34112-4961 (239) 417-6205
❒ 404 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5023
❒ 25 Homestead Road North, Suite 42 B, Lehigh Acres, Florida 33936 (239) 338-2777

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26
Meeting Date

SB 1386
Bill Number (if applicable)

Topic SB 1386 Life Insurance

Amendment Barcode (if applicable)

Name Sarah Niewold

Job Title

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Phone 425-4000

Tallahassee FL 32301
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Email SarahN@mcenanlawfirm.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing National Association of Insurance & Finance Advisors

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-26
Meeting Date

1386
Bill Number (if applicable)

Topic SB 1386

Amendment Barcode (if applicable)

Name Monte Stevens

Job Title

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Street

Phone 671 4401

Tallahassee FL 32301
City *State* *Zip*

Email Stevens@SOStrategy

Speaking: ☑ For ☐ Against ☐ Information

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

Representing SCI

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

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 1422
INTRODUCER:	Banking and Insurance Committee and Senator Simmons
SUBJECT:	Insurer Regulatory Reporting
DATE:	January 27, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			AGG	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1422 revises provisions within the Insurance Code relating to solvency requirements and regulatory oversight of insurers by the Office of Insurance Regulation (OIR). The OIR is a member of the National Association of Insurance Commissioners (NAIC), an organization consisting of state insurance regulators that establish standards and best practices, conduct peer reviews, and coordinate their regulatory oversight. As a member of the NAIC, the OIR is required to participate in the organization's accreditation program, which is a certification that the state insurance regulator is satisfying legal, regulatory, and organizational oversight standards and practices.

In response to the 2008 financial crisis, the National Association of Insurance Commissioners (NAIC) launched the Solvency Modernization Initiative, to review existing solvency oversight tools and early warning mechanisms and identify areas of potential improvement. Two of the model acts originating from this initiative are the Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act and the Corporate Governance Annual Disclosure (Corporate Governance) Model Act.

The ORSA model act requires insurers to analyze all reasonable foreseeable and relevant material risks potentially affecting their ability to meet policyholder obligations. This will provide the OIR with an effective early warning mechanism and provides a group-level perspective on risk and capital. Effective January 1, 2018, the ORSA is an NAIC accreditation

standard. The Corporate Governance model act will provide the OIR with a detailed narrative describing governance practices to promote market stability and to deter unethical behavior.

The bill implements the ORSA and Corporate Governance model acts, and:

- Provides criteria for the OIR to exempt certain insurers and insurance groups and to provide waivers of ORSA requirements;
- Provides that the ORSA and Corporate Governance filings and related documents are privileged and not subject to subpoena or discovery directly from the OIR;
- Authorizes the OIR to retain third-party consultants to assist in its administration of the bill and specifies requirements for such third-party consultants;
- Authorizes the Financial Services Commission to adopt rules to implement the ORSA and Corporate Governance requirements; and
- Authorizes the OIR to impose sanctions, for failure to submit ORSA summary reports or Corporate Governance reports.

II. Present Situation:

State Regulation of Insurance

States are the primary regulators of insurance companies. The state of domicile serves as the primary regulator for insurers. Solvency regulation is designed to protect policyholders against the risk that insurers will not be able to meet their financial responsibilities. The OIR[1] is primarily responsible for monitoring the solvency of regulated insurers and examining insurers to determine compliance with applicable laws, and taking administrative action, if necessary. Solvency regulation includes the requirements for starting and operating an insurance company,[2] monitoring the financial condition of insurers through examinations and audits, and procedures for the administrative supervision,[3] rehabilitation,[4] or liquidation[5] of an insurance company if it is in unsound financial condition or insolvent.

National Association of Insurance Commissioners Model Acts

The National Association of Insurance Commissioners is a voluntary association of insurance regulators from all 50 states. The NAIC coordinates regulation and examination of multistate insurers, provides a forum for addressing major insurance issues, and promotes uniform model laws among the states. The NAIC accreditation is a certification that a state insurance regulator is fulfilling legal, financial, and organizational standards. The NAIC establishes accreditation effective dates for states to adopt in substantially similar form models and acts for purposes of NAIC accreditation review. As a member of the NAIC, the OIR is required to participate in the

[1] Section 20.121(3)(a), F.S.
[2] Sections 624.411 - 624.414, F.S.
[3] Administrative supervision allows the Department of Financial Services (DFS) to supervise the management of a consenting troubled insurance company in an attempt to cure the company's troubles rather than close it down.
[4] In rehabilitation, the DFS is authorized as receiver to conduct all business of the insurer in an attempt to place the insurance company back in sound financial condition.
[5] In liquidation, the DFS is authorized as receiver to gather the insurance company's assets, convert them to cash, distribute them to various claimants, and shut down the company.

Financial Regulation Standards and Accreditation Program. The OIR is accredited by the NAIC. The last 5-year review occurred in 2013.

In response to the 2008 financial crisis, the NAIC launched the Solvency Modernization Initiative, to review existing solvency oversight tools and early warning mechanisms and identify areas of potential improvement. Two of the model acts emanating from this initiative are the ORSA Model Act and the Corporate Governance Annual Disclosure Model Act.

The ORSA Model Act

The ORSA Model Act requires insurers to conduct their own internal assessment of all reasonably foreseeable and relevant material risks (e.g., underwriting, credit, market) potentially affecting their ability to meet policyholder obligations. This information will provide regulators with a more comprehensive view of the ability of an insurer to withstand financial stress. According to the ORSA Model Act and ORSA Guidance Manual, the ORSA has two primary goals: "to foster an effective level of Enterprise Risk Management…;" and "provide a group-level perspective on risk and capital, as a supplement to the existing legal entity view."[6]

The ORSA Model Act requires insurers (or an insurance group, as applicable) to:

- Maintain a risk management framework for identifying assessing, monitoring, managing and reporting on its material and relevant risks;
- Conduct an ORSA at least annually; and
- File an ORSA summary report based on the ORSA Guidance Manual with their domestic regulator or lead state (for an insurance group) beginning in 2017.

The ORSA Model Act and ORSA Guidance Manual give the insurer and insurance group flexibility with respect to the form and content of the ORSA summary report, recognizing that each insurer and insurance group's business, strategic planning, and approach to enterprise risk management is unique. The ORSA summary reports are filed with the lead state regulator of the insurance group. Depending on the group, the OIR may or may not be the lead state regulator.

Insurers with direct premium below $500 million and an insurance group of which the insurer is a member with premium below $1 billion are exempt from the requirements of the ORSA Model Act. However, based on "unique circumstances," the OIR may require an exempt insurer to file an ORSA summary report. The OIR may waive the filing requirement for non-exempt insurers.

The ORSA Model Act is an NAIC accreditation standard effective January 1, 2018. Thirty-four[7] jurisdictions have adopted a substantially similar version of the ORSA Model Act. Florida has not yet adopted it in any form.

[6] National Association of Insurance Commissioners, Own Risk and Solvency Assessment (ORSA) Brief, http://www.naic.org/cipr_topics/topic_own_risk_solvency_assessment.htm (last visited Jan. 23, 2016).
[7] Office of Insurance Regulation, *Senate Bill 1422 Legislative Analysis* (Jan. 22, 2016) (on file with Banking and Insurance Committee).

Corporate Governance Model Act

During full-scope, onsite financial examinations, the OIR obtains some information on insurer governance structures, processes and practices. However, these examinations are typically limited to domestic insurers and occur only once every five years.[8] During the interval between these examinations, the OIR's access to insurer governance practices is more limited. This can mask changes and activities having a substantial bearing on the financial condition of the insurer.

The Corporate Governance Model Act is designed to provide insurance regulators with sufficient information on insurer governance structures, practices, and processes through an annual disclosure. The Corporate Governance Model Act does not mandate any particular standards or procedures beyond those already provided under state law. The NAIC simultaneously adopted a Corporate Governance Model Regulation that delineates the contents of the annual disclosure. Insurers or insurer groups must file a Corporate Governance Annual Disclosure with their domestic regulator or the lead state regulator (for an insurance group) no later than June 1 of each year beginning in 2017. The key items in the Corporate Governance disclosure include:

- The insurer's corporate governance framework and structure including duties and structure of the Board of Directors and its committees;
- The policies and practices of its Board of Directors and significant committees including appointment practices, the frequency of meetings held and review procedures;
- The policies and practices directing Senior Management including a description of defined suitability standards, the insurer's code of conduct and ethics, performance evaluation and compensation practices, and succession planning; and
- The processes by which the Board of Directors, its committees and senior management ensure an appropriate level of oversight to the critical risk areas impacting the insurer's business activities including risk management processes, the actuarial function, and investment, reinsurance and business strategy decision-making processes.

The Corporate Governance Model Act is expected to become an NAIC accreditation standard.[9] According to the NAIC, five[10] states have adopted a version of the Corporate Governance Model Act in a substantially similar form; Florida has not adopted it.

III. Effect of Proposed Changes:

Section 1 creates s. 628.8015, F.S., which requires insurers or insurance groups (if applicable), to file an ORSA and Corporate Governance information with their domestic regulator or lead state, beginning in 2017.

[8] Section 624.316 (2)(a), F.S., provides that the OIR may examine each insurer as often as may be warranted for the protection of the policyholders and in the public interest, and shall examine each domestic insurer not less frequently than once every 5 years.

[9] According to the NAIC, "The F Committee currently has out for a one year exposure the 2014 revisions to Models #305 and #306 for inclusion to the Accreditation Part A standards. The exposure period for this will end 12/31/2016. The F Committee will discuss this again at the 2017 Spring National Meeting and likely expose it for 30 days after – then consider adoption at the 2017 Summer National Meeting...if the Committee votes to adopt them into the Part A standards, the earliest it could be required for accreditation would be 1/1/19. There is a possibility the timeline could change." NAIC correspondence (Jan. 19, 2016) (on file with Senate Committee on Banking and Insurance).

[10] California, Indiana, Iowa, Louisiana, and Vermont have adopted the model act. Office of Insurance Regulation, *Senate Bill 1422 Legislative Analysis* (Jan. 22, 2016) (on file with Banking and Insurance Committee).

Definitions

In addition to defining "corporate governance annual disclosure," "ORSA," "ORSA guidance manual," and "ORSA summary report," the bill defines the following:

- "Insurer" is defined to have the same meaning as in s. 624.03, F.S.,[11] but excludes state and federal agencies, authorities, instrumentalities, possessions, territories, or political subdivisions of a state.
- "Insurance group" is defined to mean insurers and affiliates included within an insurance holding company system.
- "Senior management" is defined to mean any corporate officer responsible for reporting information to the board of directors at regular intervals or providing information to shareholders or regulators. This includes, but is not limited to, a number of executives such as chief executive officer, chief financial officer, and chief risk officer.

ORSA Provisions

The bill incorporates the three major components of the ORSA, to require insurers or insurance groups to:

- Maintain a risk management framework for identifying, assessing, monitoring, managing, and reporting on its material, relevant risks;
  - This requirement may be satisfied by being a member of an insurance group with a risk management framework applicable to the insurer's operations;
- Conduct an ORSA at least annually (and whenever there have been significant changes to the risk profile of the insurer or the insurance group), consistent with and comparable to the process in the ORSA Guidance Manual;[12]
- File an ORSA summary report, based on the ORSA Guidance Manual ,with their domestic regulator or lead state (for an insurance group), beginning in 2017, which must:
  - Be submitted once every calendar year;
  - Include notification to the OIR of its proposed annual submission date by December 1, 2016; the initial ORSA summary report must be submitted by December 31, 2017;
  - Include a brief description of material changes and updates from the prior year's report;
  - Be signed by the chief risk officer or chief executive officer responsible for overseeing the enterprise risk management process; provide copy to board of directors or appropriate board committee; and
  - Be prepared in accordance with the ORSA guidance manual and insurer must maintain and make available for OIR examination documentation and supporting information.

ORSA Exemption & Waiver

The bill exempts an insurer from the ORSA requirement if:

- Its annual direct written and unaffiliated assumed premium is less than $500 million (excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program), or

[11] Section 624.03, F.S., defines "insurer" to mean every person engaged as an indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity.

[12] The bill defines "ORSA guidance manual" as the ORSA manual developed and adopted by the NAIC. *See* NAIC, *ORSA Guidance Manual* (Jul. 2014), at http://www.naic.org/store/free/ORSA_manual.pdf.

- It is a member of an insurance group with an annual direct written and unaffiliated assumed premium of $1 billion or less (excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program).[13]

The bill also creates reporting obligations, contingent on the exempt status of the insurer and its insurance group. The OIR may still require an exempt insurer to maintain a risk management framework, conduct an ORSA, and file an ORSA summary report based on certain circumstances, such as risk-based capital that triggers a company-action-level event,[14] the exhibition of qualities of an insurer in hazardous financial condition, or if submission of the report is in the best interests of the state. In addition, the bill allows OIR to grant a waiver to an otherwise non-exempt insurer based on unique circumstances, and specifies criteria for the OIR to consider.

Corporate Governance

The bill requires insurers or insurer members of insurance groups (of which the OIR is the lead state regulator) to submit a Corporate Governance Annual Disclosure every June 1, with an initial disclosure to be submitted by December 31, 2017. The chief executive officer or corporate officer must sign the disclosure, and must describe the insurer or insurance group's governance framework and structure, relevant policies and practices, and processes for overseeing critical risk areas affecting business activities.

The bill allows insurers and insurance groups to provide corporate governance information at the ultimate controlling parent level, the intermediate holding company level, or at the individual legal entity level. Additionally, insurers and insurance groups may make their Corporate Governance Annual Disclosure at levels at which the insurer or insurance group 1) determines risk appetite, 2) oversees or exercises coordinated supervision of earnings, capital, liquidity, operations, and reputation of the insurer, or 3) at which legal liability would be placed for failure of general corporate governance duties. The insurer or insurance group must indicate their level of reporting and explain any subsequent changes, and may meet these requirements by referring other relevant and existing documents, such as the ORSA summary report, Holding Company B or F filings, and Securities and Exchange Commission proxy statements.

Insurers and insurance groups must report subsequent changes to the Corporate Governance Annual Disclosure. The lead state may request additional information and must review the Corporate Governance Annual Disclosure in accordance with the NAIC Financial Handbook. The insurer or insurance group must maintain and make available upon examination or request by the OIR any documentation and supporting information relating to the disclosure.

[13] According to the OIR, two property and casualty insurer groups and five life and health insurer groups meet the ORSA threshold and have Florida as the lead state. OIR, *Q&A on ORSA and CGAD* (Nov. 15, 2015), on file with the Banking and Insurance Committee.

[14] Section 624.81(11), F.S., authorizes the OIR to place an insurer under administrative supervision and order corrective action if the insurer is in unsound condition, exceeds its powers granted under its certificate of authority, or its practices are hazardous to the public. Commission rule defines "hazardous financial condition" in accordance with NAIC model regulation. Rule 69O-141.002, F.A.C.

Privilege & Confidentiality of ORSA and Corporate Governance

The bill provides that the ORSA and Corporate Governance filings and related documents that are submitted pursuant to this new provision, s. 628.8015, F.S., are privileged and not subject to subpoena or discovery directly from the OIR. The bill prohibits the OIR, or any person acting under the OIR's authority (such as third-party consultants), from testifying as to such filings or related documents in a private civil action. However, the OIR or the Department of Financial Services may use these filings and related documents in any regulatory or legal action it brings against an insurer as part of their official duties. The bill also provides that any applicable claims of privilege as to these filings and related documents are not waived simply because a disclosure to the OIR under this section or under any other provision of the Insurance Code. In 2014, substantially similar privilege language was enacted[15] for other insurer regulatory filings, regarding insurance holding company registration statements and annual enterprise risk reports[16] and annual actuarial opinions of reserves and supporting memoranda required of life insurers.[17]

Third-Party Consultants

The bill authorizes the OIR to retain third-party consultants at the expense of the insurer or the insurance group for assisting the OIR with ORSA and Corporate Governance Annual Disclosure responsibilities. The bill requires these third-party consultants to adhere to confidentiality and conflict of interest standards through a written agreement with the OIR. In other areas of the Insurance Code, the OIR has authority to contract with independent external auditors or examiners under the following provisions.[18]

Rulemaking

The bill authorizes the Financial Services Commission to adopt rules to administer the provisions of s. 628.8015, F.S.

Sanctions

Currently, s. 628.803, F.S., authorizes the OIR to impose sanctions on insurers and certain affiliated individuals of insurers for certain violations. The 2014 insurer solvency legislation authorizes the OIR to place an insurer under an order of supervision and to disapprove dividends or distributions, if the OIR finds that the insurer violated s. 628.461, F.S., (acquisition of controlling stock requirements) or s. 628.801, F.S., (insurance holding company registration statement and enterprise risk reporting requirements).[19]

Section 2 amends s. 628.803, F.S., to provide that the OIR may impose these fines for failure to submit an ORSA summary report or Corporate Governance Annual Disclosure, or may issue an order of supervision and disapprove dividends or distributions if an insurance company violates

[15] ch. 2014-101, ss. 8 and 11, Laws of Fla.
[16] Section 628.801(4), F.S.
[17] Section 625.1214, F.S.
[18] Section 624.316(2)(e), F.S., the OIR general examination authority; s. 624.3161(3), F.S., the OIR market conduct examination authority; s. 624.44(1)(c), F.S., multiple-employer welfare arrangements; and s. 641.27(2), F.S., health maintenance organization examinations.
[19] Section 628.803(4), F.S.; ch. 2014-101, s. 12, Laws of Fla.

s. 628.8015, F.S., which is created by this bill. The OIR may impose a penalty of $100 per day for failure to file a report, not to exceed $10,000.

Section 3 provides the act will take effect October 1, 2016, if SB 1416 or similar legislation is adopted in the same legislative session or an extension thereof and becomes a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Insurers may incur additional administrative costs associated with preparing and submitting the ORSA report and the Corporate Governance Annual Disclosure. However, under the provisions of the Corporate Governance Annual Disclosure, insurers and insurance groups are permitted to reference existing documents and filings. For purposes of ORSA filings, insurers are required to file the ORSA Summary reports with the lead state regulator of the insurance group, thereby avoiding regulatory redundancies associated with reporting in each state.

C. Government Sector Impact:

According to the OIR, implementation of the bill is expected to have an insignificant impact on technology systems. The OIR can accommodate the collection of any additional information through their current system.[20]

VI. Technical Deficiencies:

None.

[20] Office of Insurance Regulation, *Senate Bill 1422 Legislative Analysis* (Jan. 22, 2016) (on file with the Senate Committee on Banking and Insurance.)

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 628.803 of the Florida Statutes.

This bill creates section 628.8015 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 26, 2016:
The CS authorizes the Financial Services Commission to adopt rules; however, the adoption of such rules would be subject to the rule ratification provisions of s. 120.541(3), F.S. The CS also provides technical, conforming changes.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Simmons) recommended the following:

Senate Amendment

Delete lines 327 - 328
and insert:
administer this section.

197750

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Simmons) recommended the following:

Senate Amendment

Delete line 346
and insert:
SB 1416 or similar legislation is adopted in the same

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Simmons) recommended the following:

Senate Amendment

Delete lines 119 - 194
and insert:
6. The office's review of the ORSA summary report must be conducted, and any additional requests for information must be made, using procedures similar to those used in the analysis and examination of multistate or global insurers and insurance groups.
(d) *Exemption.*—

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1. An insurer is exempt from the requirements of this subsection if:

a. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $500 million; or

b. The insurer is a member of an insurance group and the insurance group has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $1 billion.

2. If an insurer is:

a. Exempt under sub-subparagraph 1.a., but the insurance group of which the insurer is a member is not exempt under sub-subparagraph 1.b., the ORSA summary report must include every insurer within the insurance group. The insurer may satisfy this requirement by submitting more than one ORSA summary report for any combination of insurers if any combination of reports includes every insurer within the insurance group.

b. Not exempt under sub-subparagraph 1.a., but the insurance group of which it is a member is exempt under sub-subparagraph 1.b., the insurer must submit to the office the ORSA summary report applicable only to that insurer.

3. The office may require an exempt insurer to maintain a risk management framework, conduct an ORSA, and file an ORSA summary report:

a. Based on unique circumstances, including, but not

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limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests;

b. If the insurer has risk-based capital for a company action level event pursuant to s. 624.4085(3), meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in rules adopted by the commission pursuant to s. 624.81(11), or exhibits qualities of an insurer in hazardous financial condition as determined by the office; or

c. If the office determines it is in the best interest of the state.

4. If an exempt insurer becomes disqualified for an exemption because of changes in premium as reported on the most recent annual statement of the insurer or annual statements of the insurers within the insurance group of which the insurer is a member, the insurer must comply with the requirements of this section effective 1 year after the year in which the insurer exceeded the premium thresholds.

(e) *Waiver.*—An insurer that does not qualify for an exemption under paragraph (d) may request a waiver from the office based upon unique circumstances. If the insurer is part of an insurance group with insurers domiciled in more than one state, the office must coordinate with the lead state and with the other domiciliary regulators in deciding whether to grant a waiver. In deciding whether to grant a waiver, the office may consider:

1. The type and volume of business written by the insurer.

2. The ownership and organizational structure of the

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insurer.

3. Any other factor the office considers relevant to the insurer or insurance group of which the insurer is a member.

A waiver granted pursuant to this paragraph is valid until withdrawn by the office.

By Senator Simmons

10-00981A-16 20161422__

A bill to be entitled

An act relating to insurer regulatory reporting; creating s. 628.8015, F.S.; defining terms; requiring an insurer to maintain a risk management framework; requiring certain insurers and insurance groups to conduct an own-risk and solvency assessment; providing requirements for the preparation and submission of an own-risk and solvency assessment summary report; providing exemptions and waivers; requiring certain insurers and members of an insurance group to prepare and submit a corporate governance annual disclosure; providing disclosure and preparation requirements; specifying privilege requirements and prohibitions for certain filings and related documents; authorizing the Office of Insurance Regulation to retain third-party consultants for certain purposes; authorizing the Financial Services Commission to adopt rules; amending s. 628.803, F.S.; revising provisions relating to penalties to conform to the act; providing a contingent effective date.

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

Section 1. Section 628.8015, Florida Statutes, is created to read:

628.8015 Own-risk and solvency assessment; corporate governance annual disclosure.—

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

(a) "Corporate governance annual disclosure" means a report filed by an insurer or insurance group in accordance with this section.

(b) "Insurance group" means insurers and affiliates

10-00981A-16 20161422__

included within an insurance holding company system.

(c) "Insurer" has the same meaning as in s. 624.03. However, the term does not include agencies, authorities, instrumentalities, possessions, or territories of the United States, the Commonwealth of Puerto Rico, or the District of Columbia; or agencies, authorities, instrumentalities, or political subdivisions of a state.

(d) "Own-risk and solvency assessment" or "ORSA" means an internal assessment, appropriate to the nature, scale, and complexity of an insurer or insurance group, conducted by that insurer or insurance group, of the material and relevant risks associated with the business plan of an insurer or insurance group and the sufficiency of capital resources to support those risks.

(e) "ORSA guidance manual" means the own-risk and solvency assessment guidance manual developed and adopted by the National Association of Insurance Commissioners.

(f) "ORSA summary report" means a high-level ORSA summary of an insurer or insurance group, consisting of a single report or combination of reports.

(g) "Senior management" means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing information to shareholders or regulators and includes, but is not limited to, the chief executive officer, chief financial officer, chief operations officer, chief risk officer, chief procurement officer, chief legal officer, chief information officer, chief technology officer, chief revenue officer, chief visionary officer, or any other executive performing one or more of these functions.

(2) OWN-RISK AND SOLVENCY ASSESSMENT.—

(a) *Risk management framework.*—An insurer shall maintain a risk management framework to assist in identifying, assessing, monitoring, managing, and reporting its material and relevant risks. An insurer may satisfy this requirement by being a member of an insurance group with a risk management framework applicable to the operations of the insurer.

(b) *ORSA requirement.*—Subject to paragraph (c), an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with and comparable to the process in the ORSA guidance manual. The ORSA must be conducted at least annually and whenever there have been significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

(c) *ORSA summary report.*—

1.a. A domestic insurer or insurer member of an insurance group of which the office is the lead state, as determined by the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook, shall:

(I) Submit an ORSA summary report to the office once every calendar year.

(II) Notify the office of its proposed annual submission date by December 1, 2016. The initial ORSA summary report must be submitted by December 31, 2017.

b. An insurer not required to submit an ORSA summary report pursuant to sub-subparagraph a. shall:

(I) Submit an ORSA summary report at the request of the office, but not more than once per calendar year.

(II) Notify the office of the proposed submission date

within 30 days after the request of the office.

2. An insurer may comply with sub-subparagraph 1.a. or sub-subparagraph 1.b. by providing the most recent and substantially similar ORSA summary report submitted by the insurer, or another member of an insurance group of which the insurer is a member, to the chief insurance regulatory official of another state or the supervisor or regulator of a foreign jurisdiction. For purposes of this subparagraph, a "substantially similar" ORSA summary report is one that contains information comparable to the information described in the ORSA guidance manual as determined by the commissioner of the office. If the report is in a language other than English, it must be accompanied by an English translation.

3. The chief risk officer or chief executive officer of the insurer or insurance group responsible for overseeing the enterprise risk management process must sign the ORSA summary report attesting that, to the best of his or her knowledge and belief, the insurer or insurance group applied the enterprise risk management process described in the ORSA summary report and provided a copy of the report to the board of directors or the appropriate board committee.

4. The ORSA summary report must be prepared in accordance with the ORSA guidance manual. Documentation and supporting information must be maintained by the insurer and made available upon examination pursuant to s. 624.316 or upon the request of the office.

5. The ORSA summary report must include a brief description of material changes and updates since the prior year report.

(d) *Exemption.*—

1. An insurer is exempt from the requirements of this subsection if:

a. The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $500 million; or

b. The insurer is a member of an insurance group and the insurance group has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and the National Flood Insurance Program, of less than $1 billion.

2. If an insurer is:

a. Exempt under sub-subparagraph 1.a., but the insurance group of which the insurer is a member is not exempt under sub-subparagraph 1.b., the ORSA summary report must include every insurer within the insurance group. The insurer may satisfy this requirement by submitting more than one ORSA summary report for any combination of insurers if any combination of reports includes every insurer within the insurance group.

b. Not exempt under sub-subparagraph 1.a., but the insurance group of which it is a member is exempt under sub-subparagraph 1.b., the insurer must submit to the office the ORSA summary report applicable only to that insurer.

3. The office may require an exempt insurer to maintain a risk management framework, conduct an ORSA, and file an ORSA summary report:

a. Based on unique circumstances, including, but not

limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests;

b. If the insurer has risk-based capital for a company action level event pursuant to s. 624.4085(3), meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in rules adopted by the commission pursuant to s. 624.81(11), or exhibits qualities of an insurer in hazardous financial condition as determined by the office; or

c. If the office determines it is in the best interest of the state.

4. If an exempt insurer becomes disqualified for an exemption because of changes in premium as reported on the most recent annual statement of the insurer or annual statements of the insurers within the insurance group of which the insurer is a member, the insurer must comply with the requirements of this section effective 1 year after the year in which the insurer exceeded the premium thresholds.

(e) *Waiver.*—An insurer that does not qualify for an exemption under paragraph (d) may request a waiver from the office based upon unique circumstances. If the insurer is part of an insurance group with insurers domiciled in more than one state, the office must coordinate with the lead state and with the other domiciliary regulators in deciding whether to grant a waiver. In deciding whether to grant a waiver, the office may consider:

1. The type and volume of business written by the insurer.

2. The ownership and organizational structure of the

insurer.

3. Any other factor the office considers relevant to the insurer or insurance group of which the insurer is a member.

A waiver granted pursuant to this paragraph is valid until withdrawn by the office.

(f) *Preparation of the ORSA summary report.*—

1. The ORSA summary report must be prepared consistent with the ORSA guidance manual, subject to the requirements of paragraph (b). Documentation and supporting information must be maintained and made available upon examination pursuant to s. 624.316 or upon the request of the office.

2. Office review of the ORSA summary report must be conducted, and any additional requests for information must be made, using procedures similar to those used in the analysis and examination of multistate or global insurers and insurance groups.

(3) CORPORATE GOVERNANCE ANNUAL DISCLOSURE.—

(a) *Scope.*—This section does not prescribe or impose corporate governance standards and internal procedures beyond those required under applicable state corporate law or limit the authority of the office, or the rights or obligations of third parties, under s. 624.316.

(b) *Disclosure requirement.*—

1.a. An insurer, or insurer member of an insurance group, of which the office is the lead state regulator, as determined by the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook, shall submit a corporate governance annual disclosure to the office by

June 1 of each calendar year. The initial corporate governance annual disclosure must be submitted by December 31, 2017.

b. An insurer or insurance group not required to submit a corporate governance annual disclosure under sub-subparagraph 1.a. shall do so at the request of the office, but not more than once per calendar year. The insurer shall notify the office of the proposed submission date within 30 days after the request of the office.

2. The chief executive officer or corporate secretary of the insurer or the insurance group must sign the corporate governance annual disclosure attesting that, to the best of his or her knowledge and belief, the insurer has implemented the corporate governance practices and provided a copy of the disclosure to the board of directors or the appropriate board committee.

3.a. Depending on the structure of its system of corporate governance, the insurer or insurance group may provide corporate governance information at one of the following levels:

(I) The ultimate controlling parent level;

(II) An intermediate holding company level; or

(III) The individual legal entity level.

b. The insurer or insurance group may make the corporate governance annual disclosure at:

(I) The level used to determine the risk appetite of the insurer or insurance group;

(II) The level at which the earnings, capital, liquidity, operations, and reputation of the insurer are collectively overseen and the supervision of those factors is coordinated and exercised; or

(III) The level at which legal liability for failure of general corporate governance duties would be placed.

An insurer or insurance group must indicate the level of reporting used and explain any subsequent changes in the reporting level.

4. The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedures in the most recent National Association of Insurance Commissioners Financial Analysis Handbook.

5. An insurer or insurance group may comply with this paragraph by cross-referencing other existing relevant and applicable documents, including, but not limited to, the ORSA summary report, Holding Company Form B or F filings, Securities and Exchange Commission proxy statements, or foreign regulatory reporting requirements, if the documents contain information substantially similar to the information described in paragraph (c). The insurer or insurance group shall clearly identify and reference the specific location of the relevant and applicable information within the corporate governance annual disclosure and attach the referenced document if it has not already been filed with, or made available to, the office.

6. Each year following the initial filing of the corporate governance annual disclosure, the insurer or insurance group shall file an amended version of the previously filed corporate governance annual disclosure indicating changes that have been made. If changes have not been made in the previously filed disclosure, the insurer or insurance group should so indicate.

(c) *Preparation of the corporate governance annual disclosure.*—

1. The corporate governance annual disclosure must be prepared in a manner consistent with this subsection. Documentation and supporting information must be maintained and made available upon examination pursuant to s. 624.316 or upon the request of the office.

2. The corporate governance annual disclosure must be as descriptive as possible and include any attachments or example documents used in the governance process.

3. The insurer or insurance group has discretion in determining the appropriate format of the corporate governance annual disclosure in communicating the required information and responding to inquiries, provided that the corporate governance annual disclosure includes material and relevant information sufficient to enable the office to understand the corporate governance structure, policies, and practices used by the insurer or insurance group.

4. The corporate governance annual disclosure must describe the:

a. Corporate governance framework and structure of the insurer or insurance group.

b. Policies and practices of the most senior governing entity and significant committees.

c. Policies and practices for directing senior management.

d. Processes by which the board, its committees, and senior management ensure an appropriate amount of oversight to the critical risk areas that have an impact on the insurer's business activities.

(4) CONFIDENTIALITY.—The filings and related documents submitted pursuant to subsections (2) and (3) are privileged and not subject to subpoena or discovery directly from the office. However, the department or office may use these filings and related documents in the furtherance of any regulatory or legal action brought against an insurer as part of the official duties of the department or office. A waiver of any applicable claim of privilege in these filings and related documents may not occur because of a disclosure to the office under this section, because of any other provision of the Insurance Code, or because of sharing under s. 624.4212. The office or a person receiving these filings and related documents, while acting under the authority of the office, or with whom such filings and related documents are shared pursuant to s. 624.4212, is not permitted or required to testify in any private civil action concerning any such filings or related documents.

(5) USE OF THIRD-PARTY CONSULTANTS.—The office may retain third-party consultants at the expense of the insurer or insurance group for the purpose of assisting it in the performance of its regulatory responsibilities under this section, including, but not limited to, the risk management framework, the ORSA, the ORSA summary report, and the corporate governance annual disclosure. A third-party consultant must agree, in writing, to:

(a) Adhere to confidentiality standards and requirements applicable to the office governing the sharing and use of such filings and related documents.

(b) Verify to the office, with notice to the insurer, that the consultant is free of any conflict of interest.

(c) Monitor compliance with applicable confidentiality and conflict of interest standards pursuant to a system of internal procedures.

(6) RULE ADOPTION.—The commission may adopt rules to administer this section. The adoption of such rules is not subject to s. 120.541(3).

Section 2. Subsections (1) and (4) of section 628.803, Florida Statutes, are amended to read:

628.803 Sanctions.—

(1) Any company failing, without just cause, to file any registration statement or certificate of exemption required to be filed pursuant to commission rules relating to this part or to submit an ORSA summary report or a corporate governance annual disclosure required pursuant to s. 628.8015 shall, in addition to other penalties prescribed under the Florida Insurance Code, be subject to pay a penalty of $100 for each day's delay, not to exceed a total of $10,000.

(4) If the office determines that any person violated s. 628.461, ~~or~~ s. 628.801, or s. 628.8015, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order of supervision in accordance with part VI of chapter 624.

Section 3. This act shall take effect October 1, 2016, if SB ____ or similar legislation is adopted in the same legislative session or an extension thereof and becomes a law.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 20, 2016

I respectfully request that **Senate Bill 1422**, relating to Insurer Regulatory Reporting, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator David Simmons
Florida Senate, District 10

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

_____ *Meeting Date*

1422 *Bill Number (if applicable)*

Topic ORSA / Corporate Governance

_____ *Amendment Barcode (if applicable)*

Name Caitlin Murray

Job Title Director of Government Affairs

Address _____ *Street*

Phone _____

_____ *City* *State* *Zip*

Email _____

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Office of Ins. Reg.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

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 1416
INTRODUCER:	Banking and Insurance Committee and Senator Simmons
SUBJECT:	Public Records/Own-risk and Solvency Assessment/Corporate Governance Annual Disclosure
DATE:	January 27, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.			GO	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1416, which is linked to SB 1422, a bill relating to insurer regulatory reporting, creates a public records exemption to incorporate the confidentiality provisions for the Office of Insurance Regulation (OIR) to meet the National Association of Insurance Commissioners' (NAIC) accreditation standards relating to two model acts. The NAIC has adopted two new insurance model acts that provide state insurance regulators new solvency regulatory tools – the Own Risk and Solvency Assessment (ORSA) and the Corporate Governance Annual Disclosure. Effective January 1, 2018, ORSA is a NAIC accreditation standard. Both model acts require that states must keep these documents confidential. The related bill, SB 1422, implements the requirements of the model acts in the Insurance Code.

Generally, the ORSA requires certain insurers to conduct an ORSA and submit an ORSA summary report to the OIR. The Corporate Governance Annual Disclosure (Corporate Governance) Model Act and corresponding Corporate Governance Annual Disclosure Model Regulations, require insurers to disclose their corporate governance structure, procedures, and practices to the OIR on an annual basis.

The bill provides that, except for information obtained by the OIR which would otherwise be available for public inspection, the following information held by the OIR is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

- An ORSA summary report, a substantially similar ORSA report, and supporting documents submitted pursuant to s. 628.8015, F.S.
- A corporate governance annual disclosure and supporting documents submitted pursuant to s. 628.8015, F.S.

The bill states that it is a public necessity to protect such information because it contain sensitive and strategic financial information and internal practices about an insurer or insurer group.

The effective date of the bill is the same date that SB 1422 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law. The bill provides for repeal of the exemption on October 2, 2021, unless reviewed and saved from repeal by the Legislature pursuant to the Open Government Sunset Review Act.

Because the bill creates a public meeting exemption, it requires a two-thirds vote of the members present and voting in each house of the Legislature for final passage.

II. Present Situation:

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]

In addition to the Florida Constitution, the Florida Statutes provide that the public may access legislative and executive branch records.[3] Chapter 119, F.S., constitutes the main body of public records laws, and is known as the Public Records Act. The Public Records Act states that

> It 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]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[5] The Florida Supreme Court has interpreted public records as being "any material prepared in connection with official

[1] FLA. CONST., art. I, s. 24(a).
[2] FLA. CONST., art. I, s. 24(a).
[3] The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). Also see *Times Pub. Co. v. Ake*, 660 So. 2d 255 (Fla. 1995). The Legislature's records are public pursuant to s. 11.0431, F.S. Public records exemptions for the Legislatures are primarily located in s. 11.0431(2)-(3), F.S.
[4] Section 119.01(1), F.S.
[5] Section 119.011(12), F.S., defines "public record" to mean "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 connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean 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 including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."

agency business which is intended to perpetuate, communicate or formalize knowledge of some type."[6] A violation of the Public Records Act may result in civil or criminal liability.[7]

The Legislature may create an exemption to public records requirements.[8] An exemption must pass by a two-thirds vote of the House and the Senate.[9] In addition, an exemption must explicitly lay out the public necessity justifying the exemption, and the exemption must be no broader than necessary to accomplish the stated purpose of the exemption.[10] A statutory exemption that does not meet these criteria may be unconstitutional and may not be judicially saved.[11]

When creating a public records exemption, the Legislature may provide that a record is 'confidential and exempt' or 'exempt.'[12] Records designated as 'confidential and exempt' may be released by the records custodian only under the circumstances defined by the Legislature. Records designated as 'exempt' may be released at the discretion of the records custodian.[13]

Regulation of Insurance

States primarily regulate insurers. The state of domicile serves as the primary regulator for insurers. Solvency regulation is designed to protect policyholders against the risk that insurers will not be able to meet their financial responsibilities. In Florida, the OIR[14] is primarily responsible for monitoring the solvency of regulated insurers and examining insurers to determine compliance with applicable laws, and taking administrative action, if necessary.

The OIR is a member of the NAIC, an organization consisting of state insurance regulators. As a member of the NAIC, the OIR is required to participate in the organization's accreditation program. The NAIC accreditation is a certification that a state regulator is complying with legal, regulatory, and organizational oversight standards. Once accredited, a member state is subject to a full accreditation review every 5 years. The NAIC also periodically reviews its solvency standards as set forth in its model acts, and revises accreditation requirements to adapt to evolving industry standards.

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[6] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc. Inc*., 379 So.2d 633, 640 (Fla. 1980).
[7] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[8] FLA. CONST., art. I, s. 24(c).
[9] FLA. CONST., art. I, s. 24(c).
[10] FLA. CONST., art. I, s. 24(c).
[11] *Halifax Hosp. Medical Center v. New-Journal Corp.*, 724 So.2d 567 (Fla. 1999). In *Halifax Hospital*, the Florida Supreme Court found that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption. *Id*. at 570. The Florida Supreme Court also declined to narrow the exemption in order to save it. *Id.* In *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So.2d 189 (Fla. 1st DCA 2004), the court found that the intent of a statute was to create a public records exemption. The *Baker County Press* court found that since the law did not contain a public necessity statement, it was unconstitutional. *Id*. at 196.
[12] If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004).
[13] A record classified as exempt from public disclosure may be disclosed under certain circumstances. *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991).
[14] Section 20.121(3)(a), F.S. (2015).

Currently, Florida's Insurance Code makes "proprietary business information"[15] contained in the certain documents confidential and exempt from s. 119.07(1), F.S., and section 24(a), Art. I, of the State Constitution. Actuarial opinion summary included with an insurer's annual financial statement,[16] actuarial opinion of life insurance reserves,[17] divestiture notice filed with the OIR,[18] holding company registration statement,[19] and enterprise risk report[20] are examples of these documents. Proprietary business information includes trade secrets, information related to competitive interests, consideration used in carrying out a merger or acquisition, information related to bids or contractual data, and internal auditing controls and internal auditor reports.[21]

Under current law, the OIR may disclose this confidential and exempt information with the written consent of the insurer, pursuant to a court order, at the request of the American Academy of Actuaries for the purpose of disciplinary proceedings, and to other governmental entities and the NAIC upon written agreement to maintain the confidential and exempt status of the information, and for the purpose of aggregating data on an industry-wide basis.[22]

The NAIC has adopted two new insurance model acts that provide state insurance regulators new solvency regulatory tools – the Own Risk and Solvency Assessment (ORSA) and the Corporate Governance Annual Disclosure (CGAD). Effective January 1, 2018, ORSA is a NAIC accreditation standard. Both model acts require that states must keep these documents confidential. The related bill, SB 1422, implements the requirements of the model acts in the Insurance Code.

III. Effect of Proposed Changes:

The bill amends s. 624.4212, F.S., to provide that ORSA summary reports, substantially similar ORSA reports, Corporate Governance reports, and supporting documents submitted pursuant to s. 628.8015, F.S. (created by the linked bill, SB 1422), are confidential and exempt from public records disclosure.

Section 1 provides that, except for information obtained by the OIR which would otherwise be available for public inspection, the following information held by the OIR is confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution:

- An ORSA summary report, a substantially similar ORSA report, and supporting documents submitted pursuant to s. 628.8015, F.S.

[15] "Proprietary business information" is defined in s. 624.4212, F.S., to mean information, regardless of form or characteristics, which is owned or controlled by an insurer, or a person or affiliated person who seeks acquisition of controlling stock in a domestic insurer or controlling is intended to be treated as private in that disclosure could harm the insurer and the information has not been disclosed except pursuant to a statutory requirement, court order or a private agreement that provides that the information will not be released to the public, and the information is not otherwise readily ascertainable or publicly available by proper means by other persons from another source.
[16] Section 624.424(1)(b), F.S.
[17] Sections 625.121(3) and 625.1212(5)(c), F.S.
[18] Section 628.461, F.S.
[19] Section 628.801(1), F.S.
[20] Section 628.801(2), F.S.
[21] Section 624.4212(1)(c), F.S.
[22] Section 624.4212(4), F.S.

- A corporate governance annual disclosure and supporting documents submitted pursuant to s. 628.8015, F.S.

The bill replaces a reference to the "American Academy of Actuaries" with the "Actuarial Board for Counseling and Discipline" for purposes of allowing the OIR sharing of confidential and exempt information for disciplinary proceedings.

Section 2. The bill states that it is a public necessity to protect the ORSA reports and related documents because the information contains sensitive and strategic financial information and internal practices about an insurer or insurer group. Further, the bill states it is a public necessity to protect the Corporate Governance Annual Disclosure and supporting documents of an insurer or insurance group because it could compromise its competitive position by revealing the insurer's governance structure and internal practices and procedures used to conduct its business affairs, make strategic operational decisions, and manage its financial condition.

Section 3. The effective date of the bill is the same date that SB 1422 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law. The bill provides for repeal of the exemption on October 2, 2021, unless reviewed and saved from repeal by the Legislature pursuant to the Open Government Sunset Review Act.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Vote Requirement

Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting in each house of the Legislature for passage of a new or expanded public records or public meetings exemption. Because this bill creates a new public records exemption, it requires a two-thirds vote for passage.

Public Necessity Statement

Article I, s. 24(c) of the Florida Constitution requires a public necessity statement for a new or expanded public records or public meetings exemption. The public necessity statement provides support for the exemption.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The public records exemption would protect sensitive and strategic financial information and internal practices about an insurer or insurer group that is reported to the OIR. The existence of the public records exemption may encourage greater comprehensive disclosure to the OIR.

C. Government Sector Impact:

The legislation would encourage cooperation among state regulatory agencies in an effort to eliminate regulatory redundancies and increase efficiencies. Other states that share regulatory filings with Florida would need to confirm that Florida is able to keep these shared filings confidential. A lack of the OIR's ability to do so would compromise the OIR's ability to coordinate with other states, and could potentially increase the regulatory filings.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 624.4212 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 26, 2016:
The CS narrows the public records exemption and provides a technical amendment.

B. Amendments:

None.

158654

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/27/2016	.	
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The Committee on Banking and Insurance (Simmons) recommended the following:

Senate Amendment

Delete line 104
and insert:
SB 1422 or similar legislation takes effect, if such legislation

647128

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/27/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Simmons) recommended the following:

Senate Amendment

Delete line 24
and insert:
(3) Except for information obtained by the office which would otherwise be available for public inspection, the following information held by the office is

By Senator Simmons

10-00982B-16 20161416__

A bill to be entitled

An act relating to public records; amending s. 624.4212, F.S.; providing an exemption from public records requirements for certain reports and documents submitted to the Office of Insurance Regulation related to an own-risk and solvency assessment by an insurer or insurance group; providing an exemption from public records requirements for a corporate governance annual disclosure and supporting documents submitted to the office; revising the actuarial board to which the office may disclose certain information; providing for and revising future legislative review and repeal; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Present subsections (3), (4), and (5) of section 624.4212, Florida Statutes, are redesignated as subsections (4), (5), and (6), respectively, and amended, and a new subsection (3) is added to that section, to read:

624.4212 Confidentiality of proprietary business and other information.—

(3) 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) An ORSA summary report, a substantially similar ORSA report, and supporting documents submitted pursuant to s. 628.8015.

(b) A corporate governance annual disclosure and supporting documents submitted pursuant to s. 628.8015.

(4)~~(3)~~ Information received from the NAIC, a ~~or another~~

10-00982B-16 20161416__

governmental entity in this or another state, the Federal Government, or a government of another nation which is confidential or exempt if held by that entity and which is held by the office for use in the ~~office's~~ performance of its duties relating to insurer valuation and solvency is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(5)~~(4)~~ The office may disclose information made confidential and exempt under this section:

(a) If the insurer to which it pertains gives prior written consent;

(b) Pursuant to a court order;

(c) To the Actuarial Board for Counseling and Discipline ~~American Academy of Actuaries~~ upon a request stating that the information is for the purpose of professional disciplinary proceedings and specifying procedures satisfactory to the office for preserving the confidentiality of the information;

(d) To other states, federal and international agencies, the National Association of Insurance Commissioners and its affiliates and subsidiaries, and state, federal, and international law enforcement authorities, including members of a supervisory college described in s. 628.805 if the recipient agrees in writing to maintain the confidential and exempt status of the document, material, or other information and has certified in writing its legal authority to maintain such confidentiality; or

(e) For the purpose of aggregating information on an industrywide basis and disclosing the information to the public only if the specific identities of the insurers, or persons or

affiliated persons, are not revealed.

(6)~~(5)~~ This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and is repealed on October 2, 2021 ~~2019~~, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that the own-risk and solvency assessment (ORSA) summary report, a substantially similar ORSA report, and supporting documents submitted to and held by the Office of Insurance Regulation pursuant to s. 628.8015, Florida Statutes, be exempt from public records requirements. In conducting this required internal assessment, an insurer or insurance group identifies and evaluates the material and relevant risks to the insurer or insurance group and the adequacy of capital resources to support these risks. The ORSA summary report, substantially similar ORSA report, and supporting documents contain highly sensitive and strategic financial information about an insurer or insurer group. Having a comprehensive and unbiased assessment will provide the office with an effective early warning mechanism for preventing insolvencies and protecting policyholders and promote a stable insurance market. Divulging the ORSA summary report, substantially similar ORSA summary report, and supporting documents will injure the insurer or insurance group by providing competitors with detailed insight into their financial position, risk management strategies, business plans, pricing and marketing strategies, management systems, and operational protocols.

(2) The Legislature finds that it is a public necessity that the corporate governance annual disclosure and supporting

documents submitted to and held by the office be exempt from public records requirements. The corporate governance annual disclosure describes an insurer's governance structure and the internal practices and procedures used in conducting the business affairs of the company, making strategic operational decisions affecting its competitive position, and managing its financial condition. Broad disclosure will give state regulators a thorough understanding of the corporate governance structure and internal policies and practices used by insurers and promote market integrity. Effective governance mechanisms will enable insurers to take any necessary corrective actions and achieve strategic goals.

Section 3. This act shall take effect on the same date that SB ____ or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 20, 2016

I respectfully request that **Senate Bill 1416**, relating to Public Records/Own-risk and Solvency Assessment, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator David Simmons
Florida Senate, District 10

File signed original with committee office

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

1416
Bill Number (if applicable)

Topic ORSA/CGAP PR

Amendment Barcode (if applicable)

Name Caitlin Murray

Job Title Director of Government Affairs

Address
Street

Phone

City State Zip

Email

Speaking: ☐ For ☒ Against ☒ Information

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

Representing OIR

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

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 1106
INTRODUCER:	Senator Flores
SUBJECT:	Limited Purpose International Trust Company Representative Offices
DATE:	January 25, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Favorable**
2.			AGG	
3.			AP	

I. Summary:

SB 1106 creates entities known as Limited Purpose International Trust Company Representative Offices (Limited Purpose ITCRO), provides registration requirements, establishes capital and insurance requirements, and provides regulatory oversight responsibilities for the Office of Financial Regulation (OFR) in relation to these entities. Under current law, an international trust company representative office (ITCRO) is an office of an international banking corporation or trust company organized and licensed under the laws of a foreign country, which is established or maintained in Florida for engaging in non-fiduciary activities described in s. 663.0625, F.S.

The bill provides that a Limited Purpose ITCRO is an office organized under the laws of Florida for engaging non-fiduciary activities, and which is not licensed as an international trust company representative office (ITCRO). The bills provides the following:

- A registered Limited Purpose ITCRO is required to maintain a minimum of $100,000 capital account. Currently, the OFR will not approve an international banking corporation to operate an ITCRO in Florida unless it meets the $20 million minimum capital requirement and meets other statutory requirements.
- The Limited Purpose ITCRO must secure a fidelity bond of at least $500,000 to indemnify the company against loss due to dishonesty, fraudulent, or criminal at or an omission of officers, directors, and employees of the company.
- The bill prescribes permissible and impermissible activities for Limited Purpose ITCROs.
- A Limited Purpose ITCRO in operation as of October 1, 2016, must apply for registration before December 31, 2016, or cease doing business in Florida.
- The OFR is required to conduct an investigation of applicants to confirm that the persons serving as officers or directors of the corporation or managers or members of a limited liability company have not been convicted of, or entered a plea of nolo contendere to, a crime involving fraud, misrepresentation, or moral turpitude.

- The bill authorizes the OFR to take specified regulatory and enforcement actions to enforce the provisions of the bill.
- The bill provides that the OFR is not responsible for examining a Limited Purpose ITCRO or an affiliated international trust company regarding safety and soundness of its operations.

II. Present Situation:

International Financial Services Market

A longstanding niche market within the international financial services market is the provision of fiduciary (trustee) services required for the implementation of estate, tax and asset protection planning. These services traditionally have comprised the administration (documentation preparation, accounting, compliance, and accounting) for a trust and its underlying investments. Services such as banking, asset management, and tax advice are provided by third parties.[1] Proponents of the bill provided the following example:

> Example: A family from Latin America purchasing a residence in Florida has a banking relationship with a Florida-based bank and is advised by Florida counsel. To avoid exposure to U.S. estate tax, the family will be advised to own the property through a non-U.S. company, as the shares in the non-U.S. company are not subject to U.S. estate tax. To provide for the family's long-term planning (local and foreign tax laws and political and security risks), the family may be advised to place the shares in the company's foreign trust.[2]

According to advocates of the bill, in the above example, responsibility for the administration of the trust and the underlying company is given to a trust company, which provides this service for an agreed fee. The trust company generally will be part of an organization that provides this service in multiple jurisdictions. The trust company, which acts as a trustee, is licensed and regulated in the jurisdiction in which it is domiciled. The trust company does not promote, sell, or accept any financial investments, money, or provide depository or custodial accounts.

The Florida-based marketing office for the aforementioned fiduciary services provided by a foreign trust company is an international trust company representative office (ITCRO). The advocates of the bill state that the primary function of the ITCRO of the foreign trust company and the organization of which it is a member is to market the trust company's services to lawyers, accountants, and financial advisors—not the general public.[3] Because many of the families who establish foreign trusts travel to Miami, the ITCROs provide a convenient way for these families to monitor the services of the international trust company without having to travel to the jurisdiction where the trust company has its operations. Thus, advocates of the bill assert that ITCROs represent an important part of Miami's role as the financial capital of the Americas and contribute in an important way to the state's economy.[4] The advocates would like to create a Limited Purpose ITCRO that would be subject to registration, clarify that the administrative and

[1] Memorandum from McDonald Hopkins LLC, *International Trust Company Representative Offices*, (Mar. 8, 2015) (on file with Senate Committee on Banking and Insurance).
[2] *Id.*
[3] *Id.*
[4] *Id.*

compliance services do not involve discretionary investment or distribution of funds and do not constitute the activities of a financial institution and should be exempt from licensure and capital requirements that apply to financial institutions.

State Regulation of International Banking Activities

The Office of Financial Regulation (OFR) is charged with regulating depository and non-depository financial institutions and financial service companies. One of the OFR's primary goals is to protect consumers from financial fraud while preserving the integrity of Florida's markets and financial service industries. To achieve this goal, the Florida Statutes provide the OFR with regulatory authority over entities regulated under the Financial Institutions Codes. [5]

International Banking Corporations

The OFR regulates international banking corporations[6] that transact business in Florida. Such entities are subject to licensure by the OFR[7] to transact business in Florida. International banking entities enable depository institutions in the United States to offer deposit and loan services to foreign residents and institutions, and are subject to the jurisdiction of the Board of Governors of the Federal Reserve. The OFR does not regulate institutions that are chartered and regulated by foreign institutions, except to the extent that those foreign institutions seek to engage in the business of banking or trust business in Florida, which requires a Florida charter and compliance with the provisions of ch. 663, F.S., and the applicable Financial Institution Codes.

An international banking corporation may operate through a variety of business models, all of which must be licensed,[8] and include international bank agencies,[9] international representative offices,[10] international trust company representative offices,[11] international administrative offices,[12] and international branches.[13] The definition of "financial institution"[14] includes international bank agency, an international banking corporation, international branch, international representative office, international administrative office, and international trust company representative office.

If an international banking corporation (IBC) wants to maintain any office in this state, including an international trust company representative office, the IBC is required to meet minimum

[5] Financial Institutions Codes include chs. 655 relating to financial institutions generally, 657 relating to banks and trust companies, 660 relating to trust business, 662 family trust companies, 663 relating to international banking, 665 relating to associations, and 657 relating to savings banks.
[6] An international banking corporation, such as a foreign commercial bank, foreign merchant bank, or other foreign institution that engages in banking activities usual in connection with the business of banking in the country where such foreign institution is organized or operating. The term also includes foreign trust companies, or any similar business entities, including, but not limited to, foreign banks with fiduciary powers, that conduct trust business as defined in the codes, Section 663.01(6), F.S.
[7] Sections 663.04 and 663.05, F.S.
[8] Section 663.06(1), F.S.
[9] Section 663.061, F.S.
[10] Section 663.062, F.S.
[11] Section 663.0625, F.S.
[12] Section 663.063, F.S.
[13] Section 663.064, F.S.
[14] Section 655.005(i), F.S.

licensure requirements, ongoing safety and soundness requirements, and is subject to the examination and enforcement authority of the OFR including state anti-money laundering and anti-terrorism laws. The OFR may not issue a license to an international banking corporation unless it:

- Holds an unrestricted license to conduct trust business in the foreign country under the law of which it is organized and chartered;
- Has been authorized by the foreign country's trust business regulatory authority to establish the proposed international trust representative office;
- Is adequately supervised by the central bank or trust regulatory agency in the foreign country in which it is organized and chartered;
- Meets all requirements under the Financial Institutions Codes for the operation of a trust company or trust department as if it was a state-chartered trust company or bank authorized to exercise fiduciary powers; and
- Meets a minimum capital requirement of $20 million.

Section 663.02, F.S., provides in general that international banking corporations having offices in Florida are subject to the provisions of ch. 655, F.S., as though such corporations were state banks or trust companies. Further, s. 663.02, F.S., provides that neither an international bank agency nor an international branch shall have any greater right under, or by virtue of s. 663.02, F.S., than is granted to banks organized under the laws of this state. Section 663.02, F.S., provides that it is the intent of the Legislature that the following provisions apply to such entities:

- Section 655.031, F.S., relating to administrative enforcement guidelines;
- Section 655.032, F.S., relating to investigations, subpoenas, hearings, and witnesses;
- Section 655.0321, F.S., relating to hearings, proceedings, related documents, and restricted access;
- Section 655.033, F.S., relating to cease and desist orders;
- Section 655.037, F.S., relating to removal by the office of an officer, director, committee member, employee, or other person;
- Section 655.041, F.S., relating to administrative fines and enforcement; and
- Section 655.50, F.S., relating to the control of money laundering and terrorist financing; and any law for which the penalty is increased under s. 775.31 F.S., for facilitating or furthering terrorism.

International Bank Agencies and International Branches. International bank agencies and international branches are permitted to conduct activities similar to those of a domestic bank. An international bank agency may make and service loans, act as a custodian, furnish investment advice, conduct foreign exchange activities and trade in securities and commercial paper.[15] An international branch has the same rights and privileges as a federally licensed international branch.[16]

International Representative Offices and International Administrative Offices. International representative offices and international administrative offices perform activities that are more limited. An international representative office may solicit business, provide information to

[15] Section 663.061, F.S.
[16] Section 663.064, F.S.

customers concerning their accounts, answer questions, receive applications for extensions of credit and other banking services, transmit documents on behalf of customers, and make arrangements for customers to transact business on their accounts. [17] An administrative office may provide personnel administration, data processing or recordkeeping, and negotiate, approve, or service loans or extensions of credit and investments.[18]

International Trust Company Representative Offices. An international trust company representative office (ITCRO) is an office of an international banking corporation or trust company organized and licensed under the laws of a foreign country, which is established or maintained in Florida for engaging in non-fiduciary activities described in s. 663.0625, F.S. An ITCRO may also include any affiliate, subsidiary, or other person that engages in such activities on behalf of such international banking corporation or trust company from an office located in Florida.[19]

ITCROs are not banks and may not accept deposits or make loans. The activities of a licensed ITCRO are limited to engaging in the following non-fiduciary activities that are ancillary to the trust business of the international banking corporation:

- Advertising, marketing, and soliciting for fiduciary business on behalf of an international banking corporation or trust company;
- Contacting existing or potential customers;
- Answering questions and providing information about matters related to customer accounts;
- Serving as a liaison in Florida between the international banking corporation or trust company and its existing or potential customers (e.g., forwarding requests for distribution or changes in investment objectives, or forwarding forms and funds received from the customer); and
- Such other activities as may be approved by the OFR or rules of the Financial Services Commission.[20]

2010 Legislation

In 2010, legislation was enacted to establish the OFR's oversight responsibilities for "offshore" international non-depository trust companies that wanted to maintain an International Trust Company Representative Office (ITCRO) in Florida. The legislation,[21] defined the ITCRO entity and established the licensing and regulatory and oversight requirements for these entities. This legislation was due, in part, to the exposure of the $8 billion dollar Ponzi scheme perpetrated by Allen Stanford.

Allen Stanford controlled an international group of privately held financial services companies under the umbrella organization Stanford Financial Group, which included Stanford Trust Company Limited, a non-depository trust company organized under the laws of Antigua and Barbuda. In late 1998, the Division of Banking of the Department of Banking and Finance[22]

[17] Section 663.062, F.S.
[18] Section 663.063, F.S.
[19] Section 663.01(9), F.S.
[20] Section 663.0625, F.S.
[21] Ch. 2010-9, Laws of Fla.
[22] Predecessor of the Division of Financial Institutions of the Office of Financial Regulation.

entered into a memorandum of understanding (MOU)[23] with the Stanford Trust Company Limited (Stanford Trust), an offshore trust company organized under the laws of Antigua and Barbados. This MOU allowed the Stanford Trust to establish a trust representative office in Florida, and delineated permissible and impermissible activities.

In this particular Ponzi scheme, certificates of deposits that promised above market rate returns were sold to customers of the Stanford Financial Group through offices in the United States and abroad with the sales of new accounts being used to fund payments on older certificates and fund Stanford's business operations and lifestyle. Because Florida law did not address representative offices of international non-depository trust companies at that time, Mr. Stanford was able to facilitate his scheme in Florida through the establishment of a representative office of Stanford Trust Company Limited in Miami, Florida. Stanford International Bank, LTD issued the certificates of deposit used to facilitate the scheme, which was also located in Antigua. The scheme is alleged to have involved over 30,000 clients in 136 countries on six continents.

In addition to attempting to address and prevent the type of scheme perpetrated by Mr. Stanford, the OFR also sought the legislation in 2010 to address issues posed by shadow banking activities conducted by unregulated entities in Florida that present a high risk of allowing money-laundering, terrorist financing, and other illicit activities to go undetected. The 2010 legislation sought to address those issues and brought ITCROs under the already-established regulatory oversight capabilities of the OFR. The OFR has the statutory regulatory responsibility for the licensing and oversight of international banking corporations that may or may not have trust powers and wish to establish representative offices, administrative offices, branches, and agencies in Florida. The law specifically provided for the licensure of representative offices of international non-depository trust companies, thereby increasing the regulatory oversight of offshore trust companies and related operations in Florida.[24]

According to advocates of SB 1106, the 2010 legislation created regulatory ambiguity for trust companies and their Florida-based marketing offices, ITCROs, potentially subjecting them to the $20 million capital requirements for operating "what is essentially a marketing and liaison office in Florida."[25] The proponents want to clarify that ITCROs that do not promote, sell, or accept any financial investments, money, or provide depository or custodial accounts and are not "financial institutions" and thus should be exempt from its licensure and capital requirements, but still subject to appropriate registration and supervision by the OFR.[26] According to the OIR, currently, the offshore/international entity that is proposing the establishment of an ITCRO is required to obtain a license under Chapter 663. By requiring only the onshore Limited Purpose ITCRO to be registered, the operations and controlling shareholders of the offshore/international non-depository trust company would be unknown and the potential risk to consumers doing business in Florida cannot be ascertained. The current process for regulation of international entities establishing representative offices in Florida provides for the identification and

[23] State of Florida, Department of Banking and Finance and Stanford Trust Company Limited, Memorandum of Agreement (Dec. 1998) (on file with Senate Committee on Banking and Insurance).
[24] Office of Financial Regulation, *2016 Legislative Agency Bill Analysis*, (Jan. 19, 2016) (on file with the Senate Committee on Banking and Insurance).
[25] Memorandum from McDonald Hopkins LLC (Mar. 8, 2015) (on file with Senate Committee on Banking and Insurance).
[26] *Id.*

understanding of the offshore/international entity, not simply the registration of the representative office in Florida.

III. Effect of Proposed Changes:

The bill establishes entities known as Limited Purpose International Trust Company Representative Offices (Limited Purpose ITCROs) that would be subject to regulation by the OFR, and creates supervisory oversight responsibilities for the OFR in relation to these entities.

Section 1 amends s. 663.01, F.S., and defines an affiliated international trust company (i.e. the offshore entity with which the proposed Limited Purpose ITCROs would be affiliated.) to mean an international trust company that is a member of the same business organization of which the Limited Purpose ITCRO is also a member; but the affiliated international trust company does not provide depository, investment management, or brokerage services in conjunction with its trust business. The definition of an affiliated international trust company states that it is not an international banking corporation, as presently defined.

This section also defines a Limited Purpose ITCRO as an office organized under the laws of this state, registered, and maintained in this state for engaging in non-fiduciary activities described in s. 663.0625(2), F.S., and which is not licensed as an ITCRO.

Sections 2 and 3 conforms cross-references.

Section 4 amends s. 663.02, F.S., relating to the applicability of state banking laws, to provide that a Limited Purpose ITCRO is not subject to the financial institutions codes, except as otherwise expressly provided in Chapter 663, F.S. The section also provides that the OFR has general supervisory powers and rulemaking authority with regard to a Limited Purpose ITCRO and that certain limitations on public records disclosure apply to a ITCRO, except where the context of such provisions clearly indicate applicability only to banks or trust companies. Further, the section establishes the OFR's ability to investigate an entity to ensure that it does not violate Ch. 663, F.S., or applicable provisions of the financial institutions codes.

Section 5 amends s. 663.03, F.S., to allow a Limited Purpose ITCRO to be organized as a corporation or a limited liability company. A Limited Purpose ITCRO would be subject to the Florida Business Corporation Act or the Florida Revised Limited Liability Company Act as though the Limited Purpose ITCRO were a foreign corporation or a foreign limited liability corporation, respectively.

Section 6 creates s. 663.045, F.S., to provide requirements for the registration of a Limited Purpose ITCRO for the approval or disapproval of an application for a Limited Purpose ITCRO. The section requires a Limited Purpose ITCRO to be registered but not licensed, and requires registration by an affiliate, subsidiary, or other person or business entity acting as an agent for, on behalf of, or for the benefit of the Limited Purpose ITCRO. The section requires a person to register with the OFR on forms prescribed by the OFR and requires that the certain information be provided to the OFR in English that includes:

- The name of the proposed Limited Purpose ITCRO, which need not be in English.

- A copy of the articles of incorporation or articles of organization, as well as the bylaws or operating agreement of the proposed ITCRO.
- The physical address and mailing address of the proposed Limited Purpose ITCRO, which must be located in this state.
- A statement describing in detail the activities of the proposed Limited Purpose ITCRO.
- The name and biographical information of each individual who will initially serve as a director, an officer, a manager, or a member acting in a managerial capacity for the proposed Limited Purpose ITCRO.
- The name of the business organization to which the Limited Purpose ITCRO belongs, together with such biographical information as the Financial Services Commission or office may reasonably require by rule for each person who, together with related interests, owns or controls, directly or indirectly, 25 percent or more of the voting stock or nonvoting stock that is convertible into voting stock of the proposed Limited Purpose ITCRO.
- The regulatory authorities that any affiliated international trust company is subject to and proof of good standing with such regulatory authorities. Such proof must be in written in English.
- The amount of the initial capital account of the proposed Limited Purpose ITCRO and the form in which the capital was paid and will be maintained, as stated in a review conducted by an independent certified public accountant licensed in this state.
- The type and amount of bonds or insurance that will be maintained by the proposed Limited Purpose ITCRO.
- A sworn statement signed by an executive officer of the applicant affirming that:
    1. The proposed Limited Purpose ITCRO is not providing depository, investment management, or fiduciary services and is providing only the permissible activities authorized in s. 663.0625(2), F.S..
    2. No director, officer, manager, or member of the proposed Limited Purpose ITCRO or of any affiliated international trust company served as a director, an officer, a manager, or a member acting in a managerial capacity for an ITCRO, an affiliated international trust company, or a financial institution that was licensed under the financial institutions codes, or by the Federal Government or any other state, the District of Columbia, a territory of the United States, or a foreign country, had that license suspended or revoked within 10 years preceding the date of the application.
    3. No director, officer, or manager of, or member acting in a managerial capacity for, the proposed Limited Purpose ITCRO or an affiliated international trust company has been convicted of, or pled guilty or nolo contendere to, regardless of whether adjudication of guilt was entered by the court, or has been the subject of a civil penalty imposed for, a violation of the financial institutions codes or a crime involving fraud, misrepresentation, or moral turpitude.
    4. No director, officer, or manager of, or member acting in a managerial capacity for, the proposed Limited Purpose ITCRO, or affiliated international trust company, has had a professional license suspended or revoked within the 10 years preceding the date of the application.
    5. All information contained in the application is true and correct to the best knowledge of the executive officer signing the sworn statement on behalf of the proposed Limited Purpose ITCRO.

Subsection (3) requires the OFR is required to conduct an investigation to confirm that the persons who will serve as directors or officers of the corporation or, if the applicant is a limited liability company, managers or members acting in a managerial capacity, have not

- Been convicted of, or entered a plea of nolo contendere to, a crime involving fraud, misrepresentation, or moral turpitude.
- Been convicted of, or entered a plea of nolo contendere to, or been the subject of a civil penalty imposed for, a violation of the financial institutions codes.
- Been directors, officers, managers, or members of a trust company or financial institution licensed or chartered under the financial institutions codes or by the Federal Government or any other state, the District of Columbia, a territory of the United States, or a foreign country and whose license or charter was suspended or revoked within the 10 years preceding the date of the application.
- Had a professional license suspended or revoked within the 10 years preceding the date of the application.
- Made a false statement of material fact on the application.

Subsection (4) requires the OFR to register the applicant to operate as a Limited Purpose ITCRO if the OFR has confirmed the applicant has met the $100,000 capital requirement; the applicant has met the requirements contained in s. 663.057, F.S., relating to maintenance of a principal office, a registered agent, state and local business licenses and permits, a deposit account, and Florida residence of at least one director or manager; the applicant has met the requirements of s. 663.058, F.S., relating to fidelity bonds and insurance; and the criteria in subsection (3) above have been satisfied. Subsection (10) provides that a registration under this chapter is valid for 1 year after the effective date.

Subsection (5) requires the OFR to notify an applicant in writing if the registration application is incomplete or if the OFR is unable to verify the information provided with the application. The applicant has 30 days after receipt of such notification to provide any required information. The OFR must deny the application if the applicant fails to timely provide such information.

Paragraph (6)(a) allows, notwithstanding the provisions of ch. 120, F.S., an application to be returned to the applicant one time for correction of substantial deficiencies, in which case the application may be resubmitted without payment of an additional fee if the application is resubmitted within 60 days. Paragraph (6)(b) allows an applicant to resubmit the application without an affiliated international trust company that is not in good standing with the relevant regulatory body or is organized and chartered in a jurisdiction that is listed on the Financial Action Task Force Public State or on its list of jurisdictions with deficiencies in anti-money laundering or counter-terrorist financing. The OFR must then allow registration of a Limited Purpose ITCRO, conditioned on it not conducting activities under s. 663.0625, F.S., with any such affiliated international trust companies that were removed from the original application.

Subsection (7) states that, notwithstanding s. 120.60(1), F.S., the OFR must approve or deny an application within 180 days after receipt of the original application or receipt of the timely requested additional information or correction of errors or omissions. An application not approved or denied within 180 days shall be deemed approved, subject to the satisfactory completion of conditions required by statute as a prerequisite to registration and approval of insurance coverage by the appropriate insurer.

Subsection (8) requires that if the OFR determines the criteria in subsection (3) have not been met, notice must be provided to the applicant of the intent to deny registration and of the applicant's right to request a hearing pursuant to ss. 120.569 and 120.57, F.S.
Subsection (9) requires that the applicant provide the OFR with a fidelity bond that meets the requirements of s. 663.058, F.S., before the OFR may grant approval of the registration.

Subsection (11) establishes that the OFR is not responsible for examining a Limited Purpose ITCRO or an affiliated international trust company regarding safety and soundness of its operations.

Subsection (12) provides that a Limited Purpose ITCRO in operation as of October 1, 2016, must apply for registration before December 31, 2016, or cease doing business in this state.

Section 7 amends subsection (3) of s. 120.80, F.S., to provide conforming changes to permit a Limited Purpose ITCRO registration.

Section 8 creates s. 663.046, F.S., providing the renewal process for a Limited Purpose ITCRO. A Limited Purpose ITCRO must file its annual renewal with the OFR, on a form prescribed by the Financial Services Commission, within 45 days before the expiration of its current registration. The renewal application must contain a sworn declaration by an executive officer, and the sworn declaration must:

- Attest that the Limited Purpose ITCRO has operated in full compliance with chs. 663, 896, F.S., or similar state or federal law, or any related rule or regulation, and with all federal laws and regulations that apply to any client of the affiliated international trust company from who it has conducted activities under s. 663.0625(2), F.S.
- Describe any material changes to the information provided under s. 663.045, F.S., regarding its operations, principal place of business, directors, officers, managers, or members acting in a managerial capacity or any affiliated international trust company since the date of registration.
- Demonstrate compliance with the minimum requirements for capital and insurance, as stated in a review prepared by an independent certified public account licensed in the state of Florida.

The annual registration renewal fee is $1,500, which is deposited into the Financial Institutions' Regulatory Trust Fund pursuant to s. 655.049, F.S. Subsection (3) provides that the provisions of s. 663.045, F.S., relating to conduct of the investigation and issuance or denial of registration apply to a registration renewal under this section.

Section 9 amends s. 663.055, F.S., to make Limited Purpose ITCROs subject to rules adopted by the Financial Services Commission relating to determining capital accounts. The section also permits a Limited Purpose ITCRO to be organized with a capital account of not less than $100,000, which must be in the form of cash or cash equivalents.

Section 10 creates s. 663.057, F.S., which defines requirements of operation and registration maintenance for a Limited Purpose ITCRO. It is required to maintain a principal office physically located in Florida where the OFR may access and examine original or true copies of all records and accounts of the Limited Purpose ITCRO in accordance with ch. 663, F.S. The

Limited Purpose ITCRO may maintain one or more branch offices within the state and must notify the OFR in writing at least 30 days before the establishment of such branch offices. A Limited Purpose ITCRO is required to maintain a registered agent who has an office in Florida. A Limited Purpose ITCRO is required to maintain a deposit account with a state-chartered or national financial institution that has a principal or branch office in Florida. A Limited Purpose ITCRO must maintain at least one director or manager who is a resident of Florida.

Section 11 creates s. 663.058, F.S., pertaining to fidelity bonds and insurance requirements. A Limited Purpose ITCRO is required to maintain a fidelity bond on all active officers, directors, managers, members acting in a managerial capacity, and employees of the company, regardless of whether they receive a salary or other compensation. The fidelity bond serves to indemnify the company against loss due to dishonest, fraudulent, or criminal acts or an omission on the part of such persons, whether acting alone or in combination with others.

An insurer authorized to do business in this state must issue the fidelity bond. The fidelity bond must be at least $500,000. The fidelity bond must be in a form satisfactory to the OFR and shall be for the benefit of any claimants in this state against the applicant to secure the faithful performance of the obligations of the applicant regarding the receipt, handling and transmission of information and documents provided to the applicant. The aggregate liability of the fidelity bond may not exceed the principal sum of the bond. Claimants against the applicant may bring suit directly on the fidelity bond, or the Department of Legal Affairs may bring suit on behalf of the claimants. The applicant or the corporate surety, except upon written notice to the office, may not cancel the fidelity bond by registered mail. A cancellation may not take effect until 30 days after receipt by the OFR of the written notice.

Subsection (3) requires that within 10 days after the payment of a fidelity bond claim, the corporate surety must give written notice to the OFR by registered mail of the payment with details sufficient to identify the claimant and the claim or judgment paid. If the principal sum of the bond is reduced by a recovery or payment, the applicant must furnish a new or additional bond so that the total or aggregate principal sum of the bond equals $500,000. As an alternative, an applicant may furnish an endorsement executed by a corporate surety reinstating the bond to the required principal sum. Subsection (5) requires the Limited Purpose ITCRO to procure and maintain general liability insurance coverage under a corporate or group policy with a minimum of $1 million per occurrence and a policy period aggregate limit of $3 million in which it is listed as an insured, to cover the acts and omissions of officers, directors, managers, members acting in a managerial capacity, and employees, regardless of whether the person receives a salary or other compensation from the company.

Section 12 amends s. 663.0625, F.S., to add the Limited Purpose ITCRO entity and to restructure certain parts of the statute pertaining to the current ITCRO entity. Section 12 of the bill also creates subsection (2) of the statute to provide that a Limited Purpose ITCRO may conduct any of the following activities:

- Participate in or attend conferences, seminars, or events that are intended for industry or professional participants and are not advertised to the public for the purposes of marketing the services of an affiliated international trust company.
- Market the services of an affiliated international trust company to lawyers, accountants, banks, licensed financial advisors, and other wealth planning professionals who are licensed

by a state, federal, or territorial government or certified by a recognized professional accrediting entity.

- In connection with the authorized activities described in the two bullets above, engage in name-recognition or branding activities in the form of signage or promotional materials that use the name of the affiliated international trust company or the name of the business organization of which the affiliated international trust company is a member.
- Assist clients or referred prospective clients of the affiliated international trust company in communicating with the affiliated international trust company, completing documentation relating to the trust relationship, and obtaining information about matters related to trust with which they are or may become associated. A Limited Purpose ITCRO may not have authority to accept such clients on behalf of the affiliated international trust company and may not otherwise bind the affiliated international trust company.
- Exercise the powers of a corporation under ch. 607, F.S., or a limited liability company under ch. 605, F.S., which are reasonably necessary to enable it to fully exercise a power enumerated in this section or authorized by ch. 663, F.S.
- Engage in any other activities consistent with this section, as prescribed by rule.

Subsection (3) is amended to create paragraphs (a)-(e) within it. Newly created paragraph (a) amends existing language of subsection (3) to cover employees, officers, or directors (rather than representatives and officers) of an ITCRO or a Limited Purpose ITCRO. These individuals may not act as a fiduciary, accept the fiduciary appointment, execute the fiduciary documents that create the fiduciary relationship, or make discretionary decisions regarding the investment or distribution of fiduciary accounts. Newly created paragraph (b) prohibits a Limited Purpose ITCRO from accepting custody of any property of the client of the affiliated international trust company on behalf of the affiliated international trust company and may not deliver such property to the affiliated international trust company. Newly created paragraph (c) prohibits a *Limited Purpose ITCRO* from soliciting business from the public on behalf of its affiliated international trust company in this state or advertise its services to the public in this state. However, this does not restrict the list of permissible activities for a Limited Purpose ITCRO. Newly created paragraph (d) prohibits a Limited Purpose ITCRO from using the words "bank," "trust," or the name of an affiliated international trust company as part of its company or fictitious name. Newly created paragraph (e) prohibits a Limited Purpose ITCRO from marketing to or discussing the services of an affiliated international trust company with any person who has not previously been referred to it by a professional described in paragraph (2)(b) or who is an existing client of an affiliated international trust company.

Subsection (4) requires that a Limited Purpose ITCRO provide the following written disclosure to a prospective or existing client of its affiliated international trust company: "(The name of the limited purpose international trust company representative office) and any affiliated international trust companies are not licensed or authorized to conduct the trust or fiduciary business in Florida." The Financial Services Commission may establish by rule the criteria for the size and font of the required disclosure.

Section 13 amends S. 663.09, F.S., by creating new subsections relating to significant events and investigations of a Limited Purpose ITCRO. Subsection (5) requires a Limited Purpose ITCRO to file reports with the OFR as prescribed by rule. The rules may prescribe such reports to be subject to examination by the OFR as a condition of granting or maintaining the registration.

Subsection (6) requires a Limited Purpose ITCRO to notify the office within 30 days of learning of the occurrence of any of the following significant events:

- Any civil, criminal, or administrative investigation or proceeding initiated by a regulatory or law enforcement authority against the Limited Purpose ITCRO
- The addition, resignation, or termination of a director or manager, an executive officer, or a member acting in a managerial capacity.
- Any change in outside accountants who are used to verify capital accounts.
- Any interruption of fidelity bonding or insurance coverage.
- Any suspected criminal act perpetrated against the Limited Purpose ITCRO. No liability shall be incurred because of making a good faith effort to fulfill this disclosure requirement.
- The loss of the charter of any affiliated international trust company.
- The loss of good standing with the applicable regulatory authorities by any affiliated international trust company.
- A change in the company name or fictitious name of the Limited Purpose ITCRO.
- A change with respect to any of the statements certified under s. 663.045, F.S.

Subsection (7) requires that the disclosure form for significant events reporting shall be specified by rule, and an executive officer of the Limited Purpose ITCRO must swear that the form is authentic and accurate.

Subsection (8) allows the OFR to conduct an investigation of a Limited Purpose ITCRO at any time it deems necessary to determine whether a Limited Purpose ITCRO has engaged in any act prohibited under s. 663.0625, F.S.

Section 14 creates S. 663.095, F.S., pertaining to the revocation of registration of a Limited Purpose ITCRO to provide that any of the following constitutes grounds for revocation of registration:

- The company is not a Limited Purpose ITCRO as defined in ch. 663, F.S.
- A violation of ss. 663.055(5), 663.057, 663.058, or 663.0625, F.S.
- A violation of chapter 896, relating to financial transaction offenses, or any similar state or federal law or any related rule or regulation.
- A violation of any Financial Services Commission rule, which continues 30 days after written notice from the OFR.
- A violation of any order of the OFR, which continues 30 days after written notice from the OFR.
- A breach of any written agreement with the OFR.
- A prohibited act or practice under s. 663.0625, F.S.
- Failure to file annual reports or provide information or documentation to the OFR upon written request.
- Conviction of a felony or entry of a plea of guilty or nolo contendere, regardless of adjudication of guilt, by the Limited Purpose ITCRO, or its officers, directors, managers, or persons acting in a managerial capacity, or an affiliated international trust company in a state or federal court, or in the courts of a foreign country with which the United States maintains diplomatic relations which involves a violation of law relating to fraud, currency transaction reporting, money laundering, theft, or a moral turpitude and the charge is equivalent to a felony charge under state or federal law.

Upon a finding of the occurrence of any of these acts, the OFR may enter an order suspending the registration and provide notice of its intention to revoke the registration and of the right to a hearing pursuant to ss. 120.569 and 120.57, F.S. The OFR may immediately enter an order revoking the registration if there has been a violation or failure to disclose a violation relating to a change to any of the statements certified under s. 633.045, F.S.

The Limited Purpose ITCRO 90 days to wind up its affairs after its registration has been revoked, during which time the Limited Purpose ITCRO may not engage in any of the activities authorized under s. 663.0625, F.S., except to the extent required to provide notice that it is winding down its affairs in this state and to provide contact information of the persons who may be contacted for additional information. If after 90 days the company has not provided satisfactory proof to the OFR that it is no longer in operation, the OFR may seek an order from the circuit court for the annulment or dissolution of the company. Satisfactory proof consists of a corporate resolution authorizing dissolution, a certified copy of articles of dissolution filed with the Division of Corporations of the Department of State, or documentation confirming the closing of the Limited Purpose ITCRO.

Section 15 creates s. 663.096, F.S., defining cease and desist authority of the OFR in relation to a Limited Purpose ITCRO. Subsection (1) defines the conduct for which the OFR may issue and serve a complaint upon a Limited Purpose ITCRO or any individual:

- Conduct that indicates the company is not a Limited Purpose ITCRO as defined in chapter 663.
- Conduct that is a violation of s. 663.055(5), s. 663.057, s. 663.058, or s. 663.0625, F.S.
- Conduct that is a violation of any Financial Services Commission rule, which continues 30 days after written notice from the OFR.
- Conduct that is a violation of any order of the OFR, which continues 30 days after written notice from the OFR.
- Conduct that is a breach of any written agreement with the OFR.
- Conduct that is a prohibited act or practice pursuant to s. 663.0625, F.S.
- Conduct that is a failure to provide information or documents to the OFR upon written request within 30 days after such request or such longer time as specified by the request.
- Conduct that is a violation of chapter 896 or similar state or federal law or any related rule or regulation.

Subsection (2) requires that the complaint contain the statement of facts and a notice of a right to a hearing pursuant to ss. 120.569 and 120.57, F.S. Subsection (3) states that if no hearing is requested within the time allowed by ss. 120.569 and 120.57, F.S., or if the hearing is held and the OFR finds that any of the charges are true, the OFR may enter an order directing the *Limited Purpose ITCRO* or the individual named therein to cease and desist from engaging in the conduct complained of and to take corrective action.
Subsection (4) provides that the failure by the Limited Purpose ITCRO or the individual named in such order to respond to the complaint within the time allotted constitutes a default, and justifies the entry of a cease and desist order. Subsection (5) establishes that a contested or default cease and desist order is effective when reduced to writing and served upon the licensed Limited Purpose ITCRO or the individual named therein. An uncontested cease and desist order will be effective as agreed.

Subsection (6) gives the OFR the ability to issue an emergency cease and desist order if it finds that conduct described in Subsection (1) has occurred which presents an imminent danger to the public. The Limited Purpose ITCRO or individual named therein must immediately cease and desist from engaging in the conduct complained of and take corrective action. The emergency order is effective immediately upon service and will remain in effect for 90 days. If, after issuance of an emergency order, the OFR begins nonemergency cease and desist proceedings under Subsection (1), the emergency order remains effective until the conclusion of the proceedings under ss. 120.569 and 120.57.

Subsection (7) provides that, subject to its rights under ch. 120, F.S., a Limited Purpose ITCRO will have 90 days to wind up its affairs after entry of an order to cease and desist operations. During the 90 days, it may not engage in any activities authorized under s. 663.0625, F.S., except to the extent required to provide notice that it is winding down its affairs in this state and to provide contact information of the persons who may be contacted for additional information. If, after 90 days, a Limited Purpose ITCRO has not provided proof satisfactory to the OFR that it has terminated operations, the OFR may seek an order from the circuit court for the annulment or dissolution of the company. Satisfactory proof consists of a corporate resolution authorizing dissolution, a certified copy of articles of dissolution filed with the Division of Corporations of the Department of State, or documentation confirming the closing of the Limited Purpose ITCRO.

Section 16 creates s. 663.115, F.S., allows a Limited Purpose ITCRO to discontinue business by filing with the OFR a certified copy of the resolution by the board of directors, or members or managers of a limited liability company, authorizing such action. The Limited Purpose ITCRO is required to voluntarily terminate its registration, which will operate to release the Limited Purpose ITCRO from any fidelity bonds it maintained.

Section 17 amends section 663.12, F.S., to provide an initial registration fee of $5,000 for a Limited Purpose ITCRO and to provide a fee amount for the conversion from registration to licensure.

Section 18 provides an effective date of October 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill creates new registration filing fee of $5,000 and new annual registration renewal fee of $1,500. According to the Florida International Administrators Association (FIAA), it has approximately a 12 members. Based on this information, the OFR projected that there will be approximately $60,000 in the first year from initial registration filing fees and then $18,000 in subsequent years from annual renewal fees.[27]

B. Private Sector Impact:

Applicants would incur an initial registration fee of $5,000, a yearly registration renewal fee of $1,500, and other indeterminate costs associated with meeting registration and regulatory requirements as a Limited Purpose ITCRO. However, such entities would be subject to less regulatory and financial requirements than ITCROs.

C. Government Sector Impact:

While the bill provides for additional duties on the OFR, no additional funds are needed to fulfill the duties, as the OFR will utilize current funding to cover any additional workload. Such duties include registration and enforcement components, and the OFR believes it is positioned to absorb the additional duties. Should the OFR see additional workload volume beyond the anticipated estimates, the OFR will reassess its funding needs and may request additional funding in future fiscal years.[28]

VI. Technical Deficiencies:

Some terms in the bill are undefined, vague, or subject to multiple interpretations.

VII. Related Issues:

The OFR has concerns regarding the regulatory framework of Limited Purpose ITCROs created in the bill.[29] According to the OFR, this legislation falls short of providing adequate standards with regard to the offshore/international entity or affiliated entities, and it fails to utilize existing standards and requirements for licensure, operation, and regulatory oversight that serve to ensure prudent operations of an offshore/international entity or affiliated entities. The activities that would be permitted for a Limited Purpose ITCRO are activities that an offshore/international trust company may currently engage in through the operation of an ITCRO in Florida. By requiring only the onshore Limited Purpose ITCRO to be registered, the operations and controlling shareholders of the offshore/international non-depository trust company would be unknown and the potential risk to consumers doing business in Florida cannot be ascertained.

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[27] Office of Financial Regulation, *2016 Agency Legislative Bill Analysis* (Jan. 19, 2016) (on file with Senate Committee on Banking and Insurance).
[28] *Id.*
[29] *Id.*

The current process for regulation of international entities establishing representative offices in Florida provides for the identification and understanding of the offshore/international entity, not simply the registration of the representative office in Florida. The legislation does not clearly require that the offshore/international entity be identified. The legislation fails to require sufficient information (such as financial condition, activities, and ownership structure) regarding the offshore/international entity, affiliated entities, or members of the "business organization" of which a Limited Purpose ITCRO is a "member." This limits the OFR's ability to assess the risk posed by the entities and the relationships between those entities, which may ultimately pose a risk to those doing business with the offshore trust company via the Florida-based Limited Purpose ITCRO. The bulk of the risks posed to consumers lies with the offshore entities, and their affiliated entities, whose activities are being marketed, yet this legislation proposes that the applicant be a Florida-based Limited Purpose ITCRO. By focusing regulatory attention on the onshore activities of a Limited Purpose ITCRO, the OFR would not be able to ascertain the risk posed by the offshore entities, and their affiliates, or the adequacy of supervision by their home country regulator.

The OFR believes that, by enacting the 2010 law, the Legislature established effective regulation of the activities of offshore trust companies that wish to have offices in Florida, and the current regulatory structure serves to impede fraudulent and other illicit activities that could be perpetrated by "offshore" international non-depository trust companies through the entities on Florida soil.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 663.01, 655.966, 662.111, 663.02, 663.03, 120.80, 663.055, 663.0625, 663.09, and 663.12

This bill creates the following sections of the Florida Statutes: 663.045, 663.046, 663.057, 663.058, 663.095, 663.096, and 663.115

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 Flores

37-00945-16 20161106__

A bill to be entitled

An act relating to limited purpose international trust company representative offices; amending s. 663.01, F.S.; defining terms; amending ss. 655.966 and 662.111, F.S.; conforming cross-references; amending s. 663.02, F.S.; providing applicability of state banking laws to limited purpose international trust company representative offices; amending s. 663.03, F.S.; revising applicability of certain acts; creating s. 663.045, F.S.; exempting a limited purpose international trust company representative office from licensing requirements; requiring certain entities to be registered; specifying required information on an application for registration; requiring a sworn statement by a specified person affirming certain statements; specifying procedures for the Office of Financial Regulation to review an application; requiring the office to register an applicant if certain criteria are satisfied; specifying procedures for incomplete or deficient applications; specifying time limits for the office to approve or deny an application; specifying procedures for the office to deny an application; requiring an applicant to provide the office with a specified fidelity bond; specifying the duration of a registration; providing that the office is not responsible for examining certain entities regarding the safety and soundness of their operations; providing applicability; amending s. 120.80, F.S.; exempting applications for registration of limited purpose international trust company representative offices from certain provisions of ch. 120, F.S.; creating s. 663.046, F.S.; providing

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procedures and a fee for registration renewals; providing applicability; amending s. 663.055, F.S.; specifying capital requirements for a limited purpose international trust company representative office; creating s. 663.057, F.S.; specifying certain requirements for a limited purpose international trust company representative office; creating s. 663.058, F.S.; requiring a limited purpose international trust company representative office to procure and maintain a specified fidelity bond to indemnify against certain loss; providing fidelity bond requirements for an applicant; providing certain requirements for a corporate surety; requiring a limited purpose international trust company representative office to procure and maintain specified liability insurance coverage to cover certain acts and omissions; amending s. 663.0625, F.S.; specifying permissible and prohibited activities by a limited purpose international trust company representative office and by certain employees; requiring a specified written disclosure; amending s. 663.09, F.S.; requiring a limited purpose international trust company representative office to file specified reports with the office; requiring a limited purpose international trust company representative office to notify the office, on a specified form and within a specified time, of certain events; authorizing the office to conduct an investigation of a limited purpose international trust company representative office;

creating s. 663.095, F.S.; providing grounds for which the office may revoke the registration of a limited purpose international trust company representative office; specifying procedures for the office to revoke a registration; authorizing the office to seek a court order to annul or dissolve a limited purpose international trust company under certain circumstances; creating s. 663.096, F.S.; authorizing the office to issue and serve a complaint for a cease and desist order based on certain violations; specifying procedures for the issuance of a cease and desist order and for contesting the office's action; specifying procedures for the issuance of an emergency cease and desist order; providing requirements for a limited purpose international trust company representative office to wind up its affairs after entry of an order; authorizing the office to seek a court order to annul or dissolve a limited purpose international trust company representative office under certain circumstances; creating s. 663.115, F.S.; providing requirements for a limited purpose international trust company representative office discontinuing its business; amending s. 663.12, F.S.; specifying fees for registration and conversion to or from a license; providing an effective date.

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

Section 1. Present subsections (1) through (9) of section

663.01, Florida Statutes, are redesignated as subsections (2) through (10), respectively, present subsections (10) and (11) of that section are redesignated as subsections (12) and (13), respectively, and new subsections (1) and (11) are added to that section, to read:

663.01 Definitions.—As used in this part, the term:

(1) "Affiliated international trust company" means an international trust company that is a member of the same business organization as a limited purpose international trust company representative office and that does not provide depository, investment management, or brokerage services in conjunction with its trust business. An affiliated international trust company is not an international banking corporation as defined in subsection (7).

(11) "Limited purpose international trust company representative office" means an office organized under the laws of this state and registered and maintained in this state for the purpose of engaging in nonfiduciary activities described in s. 663.0625(2), and which is not licensed as an international trust company representative office.

Section 2. Paragraph (a) of subsection (2) of section 655.966, Florida Statutes, is amended to read:

655.966 Automated teller machine; surcharge disclosure.—

(2)(a) Subject to the requirements of subsection (1), an agreement to operate or share an automated teller machine may not prohibit, limit, or restrict the right of the operator or owner of an automated teller machine, as defined in s. 655.960(3), to charge an access fee or surcharge, not otherwise prohibited under state or federal law, to a customer conducting

a transaction using an account from an international banking corporation as defined in s. 663.01(7) ~~s. 663.01(6)~~.

Section 3. Paragraph (e) of subsection (15) of section 662.111, Florida Statutes, is amended to read:

662.111 Definitions.—As used in this chapter, the term:

(15) "Foreign licensed family trust company" means a family trust company that:

(e) Is not owned by, or a subsidiary of, a corporation, limited liability company, or other business entity that is organized in or licensed by any foreign country as defined in s. 663.01(4) ~~s. 663.01(3)~~.

Section 4. Subsection (3) is added to section 663.02, Florida Statutes, to read:

663.02 Applicability of state banking laws.—

(3)(a) If a limited purpose international trust company representative office limits its activities to the activities authorized under s. 663.0625, other sections of the financial institutions codes do not apply to it except as otherwise expressly provided in this chapter.

(b) A limited purpose international trust company representative office is a financial institution solely for purposes of the applicability of s. 655.012, relating to general supervisory powers and rulemaking, and s. 655.057, relating to records and limitations on public access to records, except if it appears from the context that such provisions are clearly applicable only to banks or trust companies organized under the laws of this state.

(c) This section does not limit the office's authority to investigate an entity to ensure that it does not violate this

chapter or applicable provisions of the financial institutions codes.

Section 5. Section 663.03, Florida Statutes, is amended to read:

663.03 Applicability of the Florida Business Corporation Act and the Florida Revised Limited Liability Company Act.—Notwithstanding ss. 605.0102(25) and (26) and 607.01401(12) ~~s. 607.01401(12)~~, the provisions of chapter 605 and of part I of chapter 607 not in conflict with the financial institutions codes which relate to foreign limited liability companies or foreign corporations apply to all international banking corporations and their offices doing business in this state and to limited purpose international trust company representative offices.

Section 6. Section 663.045, Florida Statutes, is created to read:

663.045 Registration of a limited purpose international trust company representative office; application for registration; approval or disapproval.—

(1) A limited purpose international trust company representative office is not required to obtain a license under this chapter. However, a limited purpose international trust company representative office is required to be registered with the office if it transacts limited purpose international trust company representative office business in this state or maintains in this state any office for carrying on such business. An affiliate, subsidiary, or other person or business entity acting as an agent for, on behalf of, or for the benefit of such limited purpose international trust company

representative office, which engages in such activities in this state or maintains in this state any office for carrying on such business, is also required to be registered with the office.

(2) A person required to be registered under subsection (1) shall register with the office on forms prescribed by the office and provide the following information in English:

(a) The name of the proposed limited purpose international trust company representative office, which need not be in English.

(b) A copy of the articles of incorporation or articles of organization and the bylaws or operating agreement of the proposed limited purpose international trust company representative office.

(c) The physical address and mailing address of the proposed limited purpose international trust company representative office, which must be located in this state.

(d) A statement describing in detail the activities of the proposed limited purpose international trust company representative office.

(e) The name and biographical information of each individual who will initially serve as a director, an officer, a manager, or a member acting in a managerial capacity of the proposed limited purpose international trust company representative office.

(f) The name of the business organization to which the limited purpose international trust company representative office belongs, together with such biographical information as the commission or office may reasonably require by rule for each person who, together with related interests as defined in s.

655.005(1), owns or controls, directly or indirectly, 25 percent or more of the voting stock or nonvoting stock that is convertible into voting stock of the proposed limited purpose international trust company representative office.

(g) The regulatory authorities that any affiliated international trust company is subject to and proof of good standing with such regulatory authorities. Such proof must be translated into English if written in another language.

(h) The amount of the initial capital account of the proposed limited purpose international trust company representative office and the form in which the capital was paid and will be maintained, as stated in a review conducted by an independent certified public accountant licensed in this state.

(i) The type and amount of bonds or insurance that will be procured and maintained by the proposed limited purpose international trust company representative office pursuant to s. 663.058.

(j) A sworn statement signed by an executive officer of the applicant affirming that the following statements are true:

1. The proposed limited purpose international trust company representative office is not providing depository, investment management, or fiduciary services and is providing only the permissible activities as authorized in s. 663.0625(2).

2. No director, officer, manager, or member of the proposed limited purpose international trust company representative office or of any affiliated international trust company served as a director, an officer, a manager, or a member acting in a managerial capacity for an international trust company representative office, an affiliated international trust

company, or a financial institution that was licensed under the financial institutions codes, or by the Federal Government or any other state, the District of Columbia, a territory of the United States, or a foreign country, had that license suspended or revoked within 10 years preceding the date of the application.

3. No director, officer, or manager of, or member acting in a managerial capacity for, the proposed limited purpose international trust company representative office or an affiliated international trust company has been convicted of, or pled guilty or nolo contendere to, regardless of whether adjudication of guilt was entered by the court, or has been the subject of a civil penalty imposed for, a violation of the financial institutions codes, including s. 655.50, chapter 896, or similar state or federal law or related rule, or a crime involving fraud, misrepresentation, or moral turpitude.

4. No director, officer, or manager of, or member acting in a managerial capacity for, the proposed limited purpose international trust company representative office or affiliated international trust company has had a professional license suspended or revoked within the 10 years preceding the date of the application.

5. All information contained in the application is true and correct to the best knowledge of the executive officer signing the sworn statement on behalf of the proposed limited purpose international trust company representative office.

(k) Any other information that is consistent with this section, as required by commission rule.

(3) Upon the filing of the registration application by the

limited purpose international trust company representative office, the office shall conduct an investigation to confirm:

(a) That the persons who will serve as directors or officers of the corporation or, if the applicant is a limited liability company, managers or members acting in a managerial capacity, have not:

1. Been convicted of, or entered a plea of nolo contendere to, a crime involving fraud, misrepresentation, or moral turpitude;

2. Been convicted of, entered a plea of nolo contendere to, or been the subject of a civil penalty imposed for, a violation of the financial institutions codes, including s. 655.50, chapter 896, or similar state or federal law;

3. Been directors, officers, managers, or members of a trust company or financial institution licensed or chartered under the financial institutions codes or by the Federal Government or any other state, the District of Columbia, a territory of the United States, or a foreign country and whose license or charter was suspended or revoked within the 10 years preceding the date of the application;

4. Had a professional license suspended or revoked within the 10 years preceding the date of the application; or

5. Made a false statement of material fact on the application.

(b) That capital accounts of the proposed limited purpose international trust company conforming to s. 663.055(5) will be established and that fidelity bonds and general liability insurance coverage required under s. 663.058 will be issued and effective as of the date the limited purpose international trust

company representative office commences operations.

(c) That each affiliated international trust company with which it intends to engage in the activities authorized under s. 663.0625 is in good standing with the relevant regulatory body that supervises the activity of such international trust company.

(d) That the jurisdiction in which each affiliated international trust company is organized and chartered is not currently listed on the Financial Action Task Force Public Statement or on its list of jurisdictions with deficiencies in anti-money laundering or counter-terrorist financing.

(4) If the investigation required under this section confirms that the applicant has met the requirements of ss. 663.055(5), 663.057, and 663.058, and that the criteria in subsection (3) have been satisfied, the office shall register the applicant to operate as a limited purpose international trust company representative office.

(5) If the registration application is incomplete or the office is unable to verify the information provided with the application, the office shall notify the applicant in writing, and the applicant shall have 30 days after receipt of such notification to provide the required information. The office shall deny the application if the applicant fails to timely provide such information.

(6)(a) Notwithstanding chapter 120, an application may be returned to the applicant on a one-time basis for correction of substantial deficiencies and may be resubmitted without payment of an additional fee if the applicant resubmits the application within 60 days after the date the office returns the

application.

(b) With respect to affiliated international trust companies, if some but not all of the criteria in paragraphs (3)(c) and (d) are met, the applicant may resubmit the application without the affiliated international trust companies that do not meet the criteria, and the office shall permit registration conditioned on the limited purpose international trust company representative office not conducting activities authorized in this state under s. 663.0625 with respect to any such affiliated international trust companies that are removed from the application.

(7) Notwithstanding s. 120.60(1), an application for registration of a limited purpose international trust company representative office must be approved or denied within 180 days after receipt of the original application or receipt of the timely requested additional information or correction of errors or omissions. An application for registration not approved or denied within the 180-day period shall be deemed approved subject to the satisfactory completion of conditions required by statute as a prerequisite to registration and approval of insurance coverage by the appropriate insurer.

(8) If the office determines the criteria in subsection (3) have not been met, the office must provide the applicant with a notice of its intent to deny registration and of the applicant's right to request a hearing pursuant to ss. 120.569 and 120.57.

(9) Before the office may grant approval of a registration, the applicant must provide to the office a fidelity bond that meets the requirements of s. 663.058.

(10) A registration under this chapter shall be valid for 1

year after its effective date.

(11) The office is not responsible for examining a limited purpose international trust company representative office or an affiliated international trust company regarding the safety and soundness of its operations.

(12) A company in operation as of October 1, 2016, which meets the definition of a limited purpose international trust company representative office and is not otherwise licensed under this chapter must apply for registration as a limited purpose international trust company representative office on or before December 30, 2016, or cease doing business in this state.

Section 7. Subsection (3) of section 120.80, Florida Statutes, is amended to read:

120.80 Exceptions and special requirements; agencies.—

(3) OFFICE OF FINANCIAL REGULATION.—

(a) Notwithstanding s. 120.60(1), in proceedings for the issuance, denial, renewal, or amendment of a license or registration or approval of a merger pursuant to title XXXVIII:

1.a. The Office of Financial Regulation of the Financial Services Commission shall have published in the Florida Administrative Register notice of the application within 21 days after receipt.

b. Within 21 days after publication of notice, any person may request a hearing. Failure to request a hearing within 21 days after notice constitutes a waiver of any right to a hearing. The Office of Financial Regulation or an applicant may request a hearing at any time before ~~prior to~~ the issuance of a final order. Hearings shall be conducted pursuant to ss. 120.569 and 120.57, except that the Financial Services Commission shall

by rule provide for participation by the general public.

2. Should a hearing be requested as provided by sub-subparagraph 1.b., the applicant, ~~or~~ licensee, or registrant shall publish at its own cost a notice of the hearing in a newspaper of general circulation in the area affected by the application. The Financial Services Commission may by rule specify the format and size of the notice.

3. Notwithstanding s. 120.60(1), and except as provided in subparagraph 4., an application for license or registration for a new bank, new trust company, new credit union, new savings and loan association, ~~or~~ new licensed family trust company, or new limited purpose international trust company representative office must be approved or denied within 180 days after receipt of the original application or receipt of the timely requested additional information or correction of errors or omissions. An application for such a license or registration or for acquisition of such control which is not approved or denied within the 180-day period or within 30 days after conclusion of a public hearing on the application, whichever is later, shall be deemed approved subject to the satisfactory completion of conditions required by statute as a prerequisite to license or registration and approval of insurance of accounts for a new bank, a new savings and loan association, a new credit union, ~~or~~ a new licensed family trust company by the appropriate insurer, or a new limited purpose international trust company representative office.

4. In the case of an application for license to establish a new bank, trust company, or capital stock savings association in which a foreign national proposes to own or control 10 percent

or more of any class of voting securities, and in the case of an application by a foreign national for approval to acquire control of a bank, trust company, or capital stock savings association, the Office of Financial Regulation shall request that a public hearing be conducted pursuant to ss. 120.569 and 120.57. Notice of such hearing shall be published by the applicant as provided in subparagraph 2. The failure of such foreign national to appear personally at the hearing shall be grounds for denial of the application. Notwithstanding s. 120.60(1) and subparagraph 3., every application involving a foreign national shall be approved or denied within 1 year after receipt of the original application or any timely requested additional information or the correction of any errors or omissions, or within 30 days after the conclusion of the public hearing on the application, whichever is later.

(b) In any application for a license, registration, or merger pursuant to title XXXVIII which is referred by the agency to the division for hearing, the administrative law judge shall complete and submit to the agency and to all parties a written report consisting of findings of fact and rulings on evidentiary matters. The agency shall allow each party at least 10 days in which to submit written exceptions to the report.

Section 8. Section 663.046, Florida Statutes, is created to read:

663.046 Renewal of registration of a limited purpose international trust company representative office.—

(1) Within 45 days before the expiration of the registration, a limited purpose international trust company representative office shall file its annual renewal application

with the office on a form prescribed by the commission. The renewal application must include a sworn declaration by an executive officer of the limited purpose international trust company representative office which:

(a) Attests that the limited purpose international trust company representative office has operated in full compliance with this chapter, chapter 896, or similar state or federal law, or any related rule or regulation, and with all federal laws and regulations that apply to any client of the affiliated international trust company for whom it has conducted activities authorized under s. 663.0625(2).

(b) Describes any material changes to the information provided under s. 663.045 regarding its operations, principal place of business, directors, officers, managers, or members acting in a managerial capacity or any affiliated international trust company since the date of registration.

(c) Demonstrates that the minimum requirements for capital and insurance have been met, as stated in a review prepared by an independent certified public accountant licensed in this state.

(2) A fee of $1,500 must be submitted with the annual renewal application for registration of a limited purpose international trust company representative office. All fees received by the office pursuant to this section shall be deposited into the Financial Institutions' Regulatory Trust Fund pursuant to s. 655.049 for the purpose of administering the provisions of this chapter with respect to registration of limited purpose international trust company representative offices.

(3) The provisions of s. 663.045 relating to conduct of the investigation and issuance or denial of registration apply to a registration renewal under this section.

Section 9. Subsection (4) of section 663.055, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

663.055 Capital requirements.—

(4) For the purpose of this part, the capital accounts of an international banking corporation and a limited purpose international trust company representative office shall be determined in accordance with rules adopted by the commission. In adopting such rules, the commission shall consider similar rules adopted by bank regulatory agencies in the United States and the need to provide reasonably consistent regulatory requirements for international banking corporations which will maintain the safe and sound condition of international banking corporations doing business in this state.

(5) A limited purpose international trust company representative office may not be organized or operated with a capital account containing less than $100,000. Such capital shall be in the form of cash or cash equivalents.

Section 10. Section 663.057, Florida Statutes, is created to read:

663.057 Requirements for a limited purpose international trust company representative office.—A limited purpose international trust company representative office shall maintain:

(1) A principal office physically located in this state where original or true copies of all records and accounts of the

limited purpose international trust company representative office may be accessed and made readily available for examination by the office in accordance with this chapter. A limited purpose international trust company representative office may also maintain one or more branch offices within this state and shall notify the office in writing at least 30 days before the establishment of such branch offices.

(2) A registered agent who has an office in this state at the street address of the registered agent.

(3) All applicable state and local business licenses, charters, and permits.

(4) A deposit account with a state-chartered or national financial institution that has a principal or branch office in this state.

(5) At least one director or manager who is a resident in this state.

Section 11. Section 663.058, Florida Statutes, is created to read:

663.058 Fidelity bonds; insurance.—

(1) A limited purpose international trust company representative office shall procure and maintain a fidelity bond on all active officers, directors, managers, members acting in a managerial capacity, and employees of the company, regardless of whether they receive a salary or other compensation from the company, in order to indemnify the company against loss because of a dishonest, fraudulent, or criminal act or an omission on the part of any such persons, whether acting alone or in combination with other persons.

(2) The fidelity bond required by this section:

(a) Must be issued by an insurer authorized to do business in this state.

(b) May not be less than $500,000.

(c) Must be in a form satisfactory to the office and shall run to the state for the benefit of any claimants in this state against the applicant to secure the faithful performance of the obligations of the applicant regarding the receipt, handling, and transmission of information and documents provided to the applicant. The aggregate liability of the fidelity bond may not exceed the principal sum of the bond. Claimants against the applicant may bring suit directly on the fidelity bond, or the Department of Legal Affairs may bring suit on behalf of the claimants.

(d) May not be cancelled by the applicant or the corporate surety except upon written notice to the office by registered mail. A cancellation may not take effect until 30 days after receipt by the office of the written notice.

(3) The corporate surety must, within 10 days after it pays a claim, give written notice to the office by registered mail of the payment with details sufficient to identify the claimant and the claim or judgment paid.

(4) If the principal sum of the bond is reduced by one or more recoveries or payments, the applicant must furnish a new or additional bond so that the total or aggregate principal sum of the bond equals the sum required in paragraph (2)(b). Alternatively, an applicant may furnish an endorsement executed by the corporate surety reinstating the bond to the required principal sum.

(5) The limited purpose international trust company

representative office shall also procure and maintain general liability insurance coverage under a corporate or group policy with a minimum of $1 million per occurrence and a policy period aggregate limit of $3 million in which it is listed as an insured, to cover the acts and omissions of officers, directors, managers, members acting in a managerial capacity, and employees, regardless of whether the person receives a salary or other compensation from the company.

Section 12. Section 663.0625, Florida Statutes, is amended to read:

663.0625 International trust company representative offices and limited purpose international trust company representative offices; permissible activities~~; requirements~~.—

(1) An international trust company representative office may not act as a fiduciary, but may conduct any nonfiduciary activities that are ancillary to the fiduciary business of its international banking corporation or trust company, which ~~but may not act as a fiduciary. Permissible activities~~ include:

(a) Advertising, marketing, and soliciting for fiduciary business on behalf of an international banking corporation or trust company;

(b) Contacting existing or potential customers, answering questions, and providing information about matters related to their accounts;

(c) Serving as a liaison in this state between the international banking corporation or trust company and its existing or potential customers; and

(d) Engaging in any other activities approved by the office or under rules of the commission.

(2) A limited purpose international trust company representative office that registers pursuant to s. 663.045 may conduct any of the following activities:

(a) Participate in or attend conferences, seminars, or events that are intended for industry or professional participants and are not advertised to the general public, for the purposes of marketing the services of an affiliated international trust company.

(b) Market the services of an affiliated international trust company to lawyers, accountants, banks, licensed financial advisors, and other wealth planning professionals who are licensed by a state, federal, or territorial government or certified by a recognized professional accrediting entity.

(c) In connection with the authorized activities described in paragraphs (a) and (b), engage in name-recognition or branding activities in the form of signage or promotional materials that use the name of the affiliated international trust company or the name of the business organization of which the affiliated international trust company is a member.

(d) Assist clients or referred prospective clients of the affiliated international trust company in communicating with the affiliated international trust company, completing documentation relating to the trust relationship, and obtaining information about matters related to trusts with which they are or may become associated. However, a limited purpose international trust company representative office under this subsection may not have authority to accept such clients on behalf of the affiliated international trust company and may not otherwise bind the affiliated international trust company.

(e) Exercise the powers of a corporation under chapter 607 or a limited liability company under chapter 605 which are reasonably necessary to enable it to fully exercise a power enumerated in this section or authorized by this chapter.

(f) Engage in any other activities consistent with this section, as prescribed by commission rule.

(3)(a) ~~Representatives and~~ Employees, officers, or directors at an international trust company representative office or a limited purpose international trust company representative ~~such~~ office may not act as a fiduciary, accept ~~including, but not limited to, accepting~~ the fiduciary appointment, execute ~~executing~~ the fiduciary documents that create the fiduciary relationship, or make ~~making~~ discretionary decisions regarding the investment or distribution of fiduciary accounts.

(b) A limited purpose international trust company representative office may not accept custody of any property of the client of the affiliated international trust company on behalf of the affiliated international trust company and may not deliver such property to the affiliated international trust company.

(c) A limited purpose international trust company representative office may not solicit business from the general public on behalf of its affiliated international trust company in this state or advertise its services to the general public in this state. This paragraph does not limit a limited purpose international trust company representative office's authorized activities under subsection (2).

(d) A limited purpose international trust company

representative office may not use the words "bank," "trust," or the name of an affiliated international trust company as part of its company or fictitious name.

(e) A limited purpose international trust company representative office may not market to or discuss the services of an affiliated international trust company with any person who has not previously been referred to it by a professional described in paragraph (2)(b) or who is an existing client of an affiliated international trust company.

(4) A limited purpose international trust company representative office shall provide the following written disclosure to a prospective or existing client of its affiliated international trust company: "...(The name of the limited purpose international trust company representative office)... and any affiliated international trust companies are not licensed or authorized to conduct the trust or fiduciary business in Florida." The commission may establish by rule criteria for the size and font of the required disclosure.

Section 13. Section 663.09, Florida Statutes, is amended to read:

663.09 Reports; records; significant events; investigations.—

(1) An international banking corporation doing business in this state shall, at such times and in such form as the commission prescribes, make written reports in the English language to the office, under the oath of one of its officers, managers, or agents transacting business in this state, showing the amount of its assets and liabilities and containing such other matters as the commission or office requires. An

international banking corporation that maintains two or more offices may consolidate such information in one report unless the office otherwise requires for purposes of its supervision of the condition and operations of each such office. The late filing of such reports is subject to an administrative fine as prescribed under s. 655.045(2). If such international banking corporation fails to make such report, as directed by the office, or if such report contains a false statement knowingly made, the same shall be grounds for revocation of the license of the international banking corporation.

(2) The international banking corporation of each state-licensed international bank agency or international branch shall perform or cause to be performed an audit of such international bank agency or international branch. The commission shall, by rule, prescribe the minimum audit procedures including the audit reporting requirements which would satisfy the provisions of this subsection.

(3) Each international banking corporation which operates an office licensed under this part shall cause to be kept, at a location accepted by the office:

(a) Correct and complete books and records of account of the business operations transacted by such office. All policies and procedures governing the operations of such office, as well as any existing general ledger or subsidiary accounts, shall be maintained in the English language. The office may require that any other document not written in the English language which the office deems necessary for the purposes of its regulatory and supervisory functions be translated into English at the expense of the international banking corporation.

(b) Current copies of the charter and bylaws of the international banking corporation, relative to the operations of the office, and minutes of the proceedings of its directors, officers, or committees relative to the business of the office. Such records shall be kept pursuant to s. 655.91 and shall be made available to the office, upon request, at any time during regular business hours of the office. Any failure to keep such records as aforesaid or any refusal to produce such records upon request by the office shall be grounds for suspension or revocation of any license issued under this part.

(4) In addition to any other reports it may be required to make, an international banking corporation which maintains an international bank agency or international branch in this state shall make reports to the office in such form and at such times as the commission prescribes by rule concerning the management, asset quality, capital adequacy, and liquidity of the international banking corporation.

(5) A limited purpose international trust company representative office shall file reports with the office as the commission or the commission may prescribe by rule. The rules may prescribe such reports to be subject to examination by the office as a condition of granting or maintaining the registration.

(6) A limited purpose international trust company representative office shall notify the office within 30 days of learning of the occurrence of any of the following significant events by filing with the office a form disclosing:

(a) Any civil, criminal, or administrative investigation or proceeding initiated by a regulatory or law enforcement

authority against the limited purpose international trust company representative office;

(b) The addition, resignation, or termination of a director or manager, an executive officer, or a member acting in a managerial capacity;

(c) Any change in outside accountants who are used to verify capital accounts;

(d) Any interruption of fidelity bonding or insurance coverage;

(e) Any suspected criminal act perpetrated against the limited purpose international trust company representative office. However, no liability shall be incurred as a result of making a good faith effort to fulfill the disclosure requirement in this paragraph;

(f) The loss of the charter of any affiliated international trust company;

(g) The loss of good standing with the applicable regulatory authorities by any affiliated international trust company;

(h) A change in the company name or fictitious name of the limited purpose international trust company; or

(i) A change with respect to any of the statements certified under s. 663.045.

(7) The disclosure form shall be specified by commission rule. An executive officer of the limited purpose international trust company representative office must swear that the form is authentic and accurate.

(8) The office may conduct an investigation of a limited purpose international trust company representative office at any

time it deems necessary to determine whether a limited purpose international trust company representative office has engaged in any act prohibited under s. 663.0625.

Section 14. Section 663.095, Florida Statutes, is created to read:

663.095 Revocation of registration of a limited purpose international trust company representative office.—

(1) Any of the following constitutes grounds for the office to revoke the registration of a limited purpose international trust company representative office:

(a) The company is not a limited purpose international trust company representative office as defined in this chapter;

(b) A violation of s. 663.055(5), s. 663.057, s. 663.058, or s. 663.0625;

(c) A violation of chapter 896, relating to financial transactions offenses, or any similar state or federal law or any related rule or regulation;

(d) A violation of any commission rule which continues 30 days after written notice from the office;

(e) A violation of any order of the office which continues 30 days after written notice from the office;

(f) A breach of any written agreement with the office;

(g) A prohibited act or practice under s. 663.0625;

(h) A failure to file annual reports or provide information or documents to the office upon written request; or

(i) Conviction of a felony or entry of a plea of guilty or nolo contendere, regardless of adjudication of guilt, by the limited purpose international trust company representative office, or its officers, directors, managers, or persons acting

in a managerial capacity, or an affiliated international trust company in a state or federal court, or in the courts of a foreign country with which the United States maintains diplomatic relations which involves a violation of law relating to fraud, currency transaction reporting, money laundering, theft, or moral turpitude and the charge is equivalent to a felony charge under state or federal law.

(2)(a) Upon a finding of the occurrence of any of the acts set forth in paragraphs (1)(a)-(h), the office may enter an order suspending the company's registration and provide notice of its intention to revoke the registration and of the right to a hearing pursuant to ss. 120.569 and 120.57.

(b) If there has been a violation or failure to disclose a violation under paragraph (1)(i), the office may immediately enter an order revoking the registration.

(c) The limited purpose international trust company representative office shall have 90 days to wind up its affairs after its registration has been revoked. During such time, it may not engage in any of the activities authorized under s. 663.0625, except to the extent required to provide notice that it is winding down its affairs in this state and the name or names and contact information of the persons who may be contacted for additional information.

(d) If after 90 days the company has not provided satisfactory proof to the office that it is no longer in operation, the office may seek an order from the circuit court for the annulment or dissolution of the company. Satisfactory proof shall consist of a corporate resolution authorizing dissolution, a certified copy of articles of dissolution filed

with the Division of Corporations of the Department of State, or documentation confirming the closing of the limited purpose international trust company representative office.

Section 15. Section 663.096, Florida Statutes, is created to read:

663.096 Cease and desist authority.—

(1) The office may issue and serve a complaint upon a limited purpose international trust company representative office or any individual if the office has reason to believe that the limited purpose international trust company representative office or individual named therein is engaging in or has engaged in conduct that:

(a) Indicates the company is not a limited purpose international trust company representative office as defined in this chapter;

(b) Is a violation of s. 663.055(5), s. 663.057, s. 663.058, or s. 663.0625;

(c) Is a violation of any commission rule which continues 30 days after written notice from the office;

(d) Is a violation of any order of the office which continues 30 days after written notice from the office;

(e) Is a breach of any written agreement with the office;

(f) Is a prohibited act or practice pursuant to s. 663.0625;

(g) Is a failure to provide information or documents to the office upon written request within 30 days after such request or such longer time as specified in the request; or

(h) Is a violation of chapter 896 or similar state or federal law or any related rule or regulation.

(2) The complaint must contain the statement of facts and a notice of right to a hearing pursuant to ss. 120.569 and 120.57.

(3) If no hearing is requested within the time allowed by ss. 120.569 and 120.57, or if a hearing is held and the office finds that any of the charges are true, the office may enter an order directing the limited purpose international trust company representative office or the individual named therein to cease and desist from engaging in the conduct complained of and to take corrective action.

(4) If the limited purpose international trust company representative office or the individual named in such order fails to respond to the complaint within the time allotted in ss. 120.569 and 120.57, such failure constitutes a default and justifies the entry of a cease and desist order.

(5) A contested or default cease and desist order is effective when reduced to writing and served upon the licensed limited purpose international trust company representative office or the individual named therein. An uncontested cease and desist order is effective as agreed.

(6) If the office finds that conduct described in subsection (1) has occurred which presents an imminent danger to the public, it may issue an emergency cease and desist order requiring the limited purpose international trust company representative office or individual named therein to immediately cease and desist from engaging in the conduct complained of and to take corrective action. The emergency order is effective immediately upon service of a copy of the order upon the limited purpose international trust company representative office or individual named therein and remains effective for 90 days. If

the office begins nonemergency cease and desist proceedings under subsection (1), the emergency order remains effective until the conclusion of the proceedings under ss. 120.569 and 120.57.

(7) Subject to its rights under chapter 120, a limited purpose international trust company representative office shall have 90 days to wind up its affairs after entry of an order to cease and desist from operating as a limited purpose international trust company representative office. During such time, it may not engage in any of the activities authorized under s. 663.0625, except to the extent required to provide notice that it is winding down its affairs in this state and the name or names and contact information of the persons who may be contacted for additional information. If, after 90 days, a limited purpose international trust company representative office has not provided proof satisfactory to the office that it has terminated operations, the office may seek an order from the circuit court for the annulment or dissolution of the company. Satisfactory proof shall consist of a corporate resolution authorizing dissolution, a certified copy of articles of dissolution filed with the Division of Corporations of the Department of State, or documentation confirming the closing of the limited purpose international trust company representative office.

Section 16. Section 663.115, Florida Statutes, is created to read:

663.115 Discontinuing business.—If a limited purpose international trust company representative office desires to discontinue business, it must file with the office a certified

copy of the resolution of the board of directors, or members or managers of a limited liability company, authorizing that action. The limited purpose international trust company representative office shall voluntarily terminate its registration as a limited purpose international trust company representative office, whereupon it shall be released from any fidelity bonds that it maintained pursuant to s. 663.058.

Section 17. Subsection (1) of section 663.12, Florida Statutes, is amended to read:

663.12 Fees; assessments; fines.—

(1) Each application for a license or registration under ~~the provisions of~~ this part shall be accompanied by a nonrefundable filing fee payable to the office in the following amount:

(a) Ten thousand dollars for establishing a state-chartered investment company.

(b) Ten thousand dollars for establishing an international bank agency or branch.

(c) Five thousand dollars for establishing an international administrative office.

(d) Five thousand dollars for establishing an international representative office.

(e) Five thousand dollars for establishing an international trust company representative office or a limited purpose international trust company representative office.

(f) An amount equal to the initial filing fee for an application to convert from one type of license to another or from a registration to a license. The commission may increase the filing fee for any type of license or registration to an

amount established by rule and calculated in a manner so as to cover the direct and indirect cost of processing such applications.

Section 18. This act shall take effect October 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 13, 2016

I respectfully request that **Senate Bill #1106**, relating to Limited Purpose International Trust Company Representative Offices, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Anitere Flores

Senator Anitere Flores
Florida Senate, District 37

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/25/16
Meeting Date

1106
Bill Number (if applicable)

Topic International Trust Co Rep Office

Amendment Barcode (if applicable)

Name MARCIA SEIBALD

Job Title Former President

Address 701 Brickell Ave
Street

Phone 305-577-0233

Miami FLA 33131
City *State* *Zip*

Email mseibald@citco.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing ~~Corporate~~ CITCO CORP Services Inc

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/25/16
Meeting Date

1106
Bill Number (if applicable)

Topic International Trust Co. Representative Offices
Amendment Barcode (if applicable)

Name Raquel A. Rodriguez

Job Title Attorney

Address 200 S. Biscayne Blvd., Suite 2600
Street

Phone 305-704-3994

MIAMI
City

FL
State

33149
Zip

Email rrodriguez@mcdonaldhopkins.com

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Florida International Administrators Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/25/16
Meeting Date

1106
Bill Number (if applicable)

Topic SB 1106 - Linked Purpose ITCRO

Amendment Barcode (if applicable)

Name Robert Payne

Job Title Trust Director

Address 1001 Brickell Bay Dr, ST 2306
Street

Phone 305 416 4738

Miami FL 33131
City *State* *Zip*

Email r.payne@amicorp.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Amicorp Services LTD.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

1106
Bill Number (if applicable)

Topic INTERNATIONAL TRUST COMPANY REP. OFFICE
Amendment Barcode (if applicable)

Name TOMAS ALONSO

Job Title MANAGING DIRECTOR

Address 1001 BRICKELL BAY DR., SUITE 2306
Street

Phone (305) 4164730

MIAMI FLA 33131
City *State* *Zip*

Email t.alonso@amicorp.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing AMICORP SERVICES LTD.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

SB 1106 / [illegible]
Bill Number (if applicable)

Topic LIMITED PURPOSE INTERNATIONAL TRUST COMPANY

Amendment Barcode (if applicable)

Name ERNESTO MAIRHOFER

Job Title DIRECTOR

Address 701 BRICKELL AVE Suite 2600
Street

Phone 305 577 0233

MIAMI FL 33149
City *State* *Zip*

Email emairhofer@citco.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing CITCO CORPORATE SERVICES INC.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/2016
Meeting Date

SB 1106
Bill Number (if applicable)

Topic LIMITED PURPOSE INT'L TRUST COMPANY

Amendment Barcode (if applicable)

Name JOHN RYAN

Job Title PRESIDENT

Address 701 BRICKELL AVENUE, SUITE 1440
Street

Phone 305 728 8820

MIAMI FL 33131
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing CISA LATAM LLC

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

SB 1106
Bill Number (if applicable)

Topic Speaking in Opposition to SB 1106

Amendment Barcode (if applicable)

Name Drew J. Breakspear

Job Title Commissioner of Office of Financial Regulation

Address 101 E Gaines Street
Street

Phone 850-410-9601

Tallahassee *City* | Florida *State* | 32399 *Zip*

Email jamie.mongiovi@flofr.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Office of Financial Regulation

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/2016
Meeting Date

1106
Bill Number (if applicable)

Topic INTERNATIONAL TRUST CO REP OFFICES
Amendment Barcode (if applicable)

Name SLATER BAILISS

Job Title

Address 215 S. MONROE ST #607
Street

Phone 850 222 8900

TALLAHASSEE FL 32301
City *State* *Zip*

Email sw@caridenas.partners

Speaking: ☐ For ☐ Against ☐ Information

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

Representing THE FLORIDA ASSOCIATION OF ADMINISTRATORS

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

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 1094
INTRODUCER:	Banking and Insurance Committee and Senator Flores
SUBJECT:	Public Records/Limited Purpose International Trust Company
DATE:	January 27, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Knudson	BI	**Fav/CS**
2.			GO	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 1094 creates a new exemption from the public records inspection and access requirements of Art. I, s. 24(a) of the State Constitution and s. 119.07(1), F.S., for information held by the Office of Financial Regulation (OFR) relating to the regulation of limited purpose International Trust Company Representative Offices (ITCROs). The public records exemption encompasses:

- Personal identifying information appearing in records relating to an application, or a new or renewal registration of a limited purpose international trust company representative office.
- Personal identifying information appearing in reports, investigations, and records relating to an investigation of a limited purpose international trust company representative office.
- Names of existing or prospective clients of an affiliated international trust company.
- Information received by the OFR from another state, nation, or the federal government that is otherwise confidential or exempt pursuant to the laws of that state or nation, or pursuant to federal law.

The bill allows the OFR to disclose information in specified circumstances that would otherwise be held confidential and exempt pursuant to the bill.

Under the bill, the willful disclosure of information made confidential and exempt by this public records exemption is a third degree felony.

The bill provides a statement of public necessity.

The public records exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

The bill will take effect on the same date that SB 1106, or similar legislation, is adopted during the same legislative session, or extension, and becomes a law.

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]

In addition to the Florida Constitution, the Florida Statutes provide that the public may access legislative and executive branch records.[3] Chapter 119, F.S., constitutes the main body of public records laws, and is known as the Public Records Act.[4] The Public Records Act states that

> it 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.[5]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[6] The Florida Supreme Court has interpreted public records as being "any material prepared in connection with official agency business which is intended to perpetuate, communicate or formalize knowledge of some type."[7] A violation of the Public Records Act may result in civil or criminal liability.[8]

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[1] FLA. CONST., art. I, s. 24(a).
[2] FLA. CONST., art. I, s. 24(a).
[3] The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So2d 32 (Fla. 1992). Also see *Times Pub. Co. v. Ake*, 660 So.2d 255 (Fla. 1995). The Legislature's records are public pursuant to s. 11.0431, F.S. Public records exemptions for the Legislatures are primarily located in s. 11.0431(2)-(3), F.S.
[4] Public records laws are found throughout the Florida Statutes.
[5] s. 119.01(1), F.S.
[6] s. 119.011(12), F.S., defines "public record" to mean "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 connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[7] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc. Inc*., 379 So.2d 633, 640 (Fla. 1980).
[8] s. 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.

The Legislature may create an exemption to public records requirements.[9] An exemption must pass by a two-thirds vote of the House and the Senate.[10] In addition, an exemption must explicitly lay out the public necessity justifying the exemption, and the exemption must be no broader than necessary to accomplish the stated purpose of the exemption.[11] A statutory exemption which does not meet these criteria may be unconstitutional and may not be judicially saved.[12]

When creating a public records exemption, the Legislature may provide that a record is 'confidential and exempt' or 'exempt.'[13] Records designated as 'confidential and exempt' may be released by the records custodian only under the circumstances defined by the Legislature. Records designated as 'exempt' may be released at the discretion of the records custodian.[14]

Open Government Sunset Review Act

In addition to the constitutional requirements relating to the enactment of a public records exemption, the Legislature may subject the new or broadened exemption to the Open Government Sunset Review Act (OGSR).

The OGSR prescribes a legislative review process for newly created or substantially amended public records.[15] The OGSR provides that an exemption automatically repeals 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.[16] In practice, many exemptions are continued by repealing the sunset date rather than reenacting the exemption.

Under the OGSR the purpose and necessity of reenacting the exemption are reviewed. The Legislature must consider the following questions during its review of an exemption:[17]

- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?

[9] FLA. CONST., art. I, s. 24(c).
[10] FLA. CONST., art. I, s. 24(c).
[11] FLA. CONST., art. I, s. 24(c).
[12] *Halifax Hosp. Medical Center v. New-Journal Corp.*, 724 So2d 567 (Fla. 1999). In *Halifax Hospital*, the Florida Supreme Court found that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption. *Id*. at 570. The Florida Supreme Court also declined to narrow the exemption in order to save it. *Id.* In *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So.2d 189 (Fla. 1st DCA 2004), the court found that the intent of a statute was to create a public records exemption. The *Baker County Press* court found that since the law did not contain a public necessity statement, it was unconstitutional. *Id*. at 196.
[13] If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004).
[14] A record classified as exempt from public disclosure may be disclosed under certain circumstances. *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991).
[15] Section 119.15, F.S. According to s. 119.15(4)(b), F.S., a substantially amended exemption is one that is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to s. 119.15(2), F.S. The OGSR process is currently being followed; however, the Legislature is not required to continue to do so. The Florida Supreme Court has found that one legislature cannot bind a future legislature. *Scott v. Williams*, 107 So.3d 379 (Fla. 2013).
[16] s. 119.15(3), F.S.
[17] s. 119.15(6)(a), F.S.

- 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?

If the Legislature expands an exemption, then a public necessity statement and a two-thirds vote for passage are required.[18] If the exemption is reenacted 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 sunset, the previously exempt records will remain exempt unless otherwise provided for by law.[19]

International Financial Services Market

SB 1106 would create a Limited Purpose ITCRO that would be subject to registration, clarify that the administrative and compliance services do not involve discretionary investment or distribution of funds and do not constitute the activities of a financial institution and should be exempt from licensure and capital requirements that apply to financial institutions.

A longstanding niche market within the international financial services market is the provision of fiduciary (trustee) services required for the implementation of estate, tax and asset protection planning. These services traditionally have comprised the administration (documentation preparation, accounting, compliance, and accounting) for a trust and its underlying investments. Services such as banking, asset management, and tax advice are provided by third parties.[20] Proponents of the bill provided the following example:

Example: A family from Latin America purchasing a residence in Florida has a banking relationship with a Florida-based bank and is advised by Florida counsel. To avoid exposure to U.S. estate tax, the family will be advised to own the property through a non-U.S. company, as the shares in the non-U.S. company are not subject to U.S. estate tax. To provide for the family's long-term planning (local and foreign tax laws and political and security risks), the family may be advised to place the shares in the company's foreign trust.[21]

According to advocates of the bill, in the above example, responsibility for the administration of the trust and the underlying company is given to a trust company, which provides this service for an agreed fee. The trust company generally will be part of an organization that provides this service in multiple jurisdictions. The trust company, which acts as a trustee, is licensed and regulated in the jurisdiction in which it is domiciled. The trust company does not promote, sell, or accept any financial investments, money, or provide depository or custodial accounts.

[18] FLA. CONST., art. I, s. 24(c).
[19] s. 119.15(7), F.S.
[20] Memorandum from McDonald Hopkins LLC, *International Trust Company Representative Offices,* (Mar. 8, 2015) (on file with Senate Committee on Banking and Insurance).
[21] *Id.*

The Florida-based marketing office for the aforementioned fiduciary services provided by a foreign trust company is an international trust company representative office (ITCRO). The advocates of the bill state that the primary function of the ITCRO of the foreign trust company and the organization of which it is a member is to market the trust company's services to lawyers, accountants, and financial advisors—not the general public.[22] Because many of the families who establish foreign trusts travel to Miami, the ITCROs provide a convenient way for these families to monitor the services of the international trust company without having to travel to the jurisdiction where the trust company has its operations. Thus, advocates of the bill assert that ITCROs represent an important part of Miami's role as the financial capital of the Americas and contribute in an important way to the state's economy.[23]

III. Effect of Proposed Changes:

CS/SB 1094 creates a new exemption from the public records inspection and access requirements of Art. I, s. 24(a) of the State Constitution and s. 119.07(1), F.S., for information held by the Office of Financial Regulation (OFR) related to the regulation of limited purpose International Trust Company Representative Offices (ITCROs).

Scope of the Exemption

The public records exemption encompasses:

- Personal identifying information appearing in records relating to an application, or a new or renewal registration of a limited purpose international trust company representative office.
- Personal identifying information appearing in reports, investigations, and records relating to an investigation of a limited purpose international trust company representative office.
- Names of existing or prospective clients of an affiliated international trust company. The purpose of this exemption is to shield the identities of high worth individuals who could be targets of criminal predators seeking access to their assets.
- Information received by the OFR from another state, nation, or the federal government that is otherwise confidential or exempt pursuant to the laws of that state or nation, or pursuant to federal law.

The bill authorizes the release of information subject to the public records exemption in the following circumstances:

- To the authorized representative(s) of the limited purpose ITCRO that is the subject of a report or investigation. Such persons shall be identified in a resolution or by written consent of the board of directors (if a corporation) or managers (if a limited liability company) of the limited purpose ITCRO.
- If the board of directors or managers of a limited purpose ITCRO consent in writing, to a fidelity insurance company or liability insurer. The OFR objects to the limited purpose ITCRO having authority to determine whether a record may be released.[24]

[22] *Id.*
[23] *Id.*
[24] Office of Financial Regulation, 2016 Agency Legislative Bill Analysis SB 1094 (Jan. 19, 2016)(on file with the Senate Committee on Banking and Insurance).

- If the board of directors or managers of a limited purpose ITCRO consent in writing, to an independent auditor. The OFR objects to the limited purpose ITCRO having authority to determine whether a record may be released.[25]
- To a liquidator, receiver, or conservator for a limited purpose ITCRO if a liquidator, receiver, or conservator is appointed; however, the identities of current or prospective clients must be redacted. The OFR believes that the requirement to redact such names would inhibit the ability of the liquidator, receiver, or conservator to fulfill its duties if it cannot identify the individuals and entities the limited purpose ITCRO has dealt with.[26]
- To any other state, federal, or foreign agency responsible for the regulation or supervision of limited purpose ITCROs or an affiliated international trust company.
- To a law enforcement agency in the furtherance of the agency's official duties and responsibilities.
- Pursuant to a legislative subpoena. The legislative body must maintain the confidential status of such records or information except when the subpoena involves the investigation of charges against a public official subject to impeachment or removal.

The public records exemption does not apply to the name of the limited purpose ITCRO; the name of any affiliated international trust company; and the names and addresses of the directors, managers, officers, or registered agent of the limited purpose ITCRO or any affiliated international trust company. The public records exemption also does not prevent or apply to the publication of a report required by federal law.

Penalty for Willful Disclosure

Under the bill, the willful disclosure of information made confidential and exempt by this public records exemption is a third degree felony.

Repeal Date Pursuant to the Open Government Sunset Review Act

The public records exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.15, F.S. It shall stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

Statement of Public Necessity and Legislative Findings

The bill states that the Legislature finds it a public necessity to hold exempt from public records requirements the information that is subject to this public records exemption. Specifically, the bill states that disclosure of the financial information and lists of names of clients or prospective clients would jeopardize the personal and financial safety of such persons because families with high net worth are targeted by criminal predators seeking access to their assets. The exposure of their identities and financial information could expose such persons to increased threats of extortion, kidnapping and other crimes, especially because many of the clients and prospective clients of affiliated international trust companies reside in or frequently travel to countries in

[25] *See* Office of Financial Regulation, *supra* note 20.
[26] *See* Office of Financial Regulation, *supra* note 20.

which kidnapping and extortion are significant risks and public corruption impedes the rule of law.

The Legislature also finds that it is a public necessity to exempt from public records requirements information received by the OFR from a person from another state or nation or the Federal Government with is otherwise confidential or exempt pursuant to the laws of that state or nation or federal law. The Legislature finds that maintaining such confidentiality is necessary to protect the sensitive nature of the information and to facilitate the sharing of such information for the OFR's effective and efficient performance of its duties.

Effective Date

The public records exemption in this bill will take effect on the same date that SB 1106 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof.

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 newly created or expanded public record or public meeting exemption. This bill creates a public record exemption; thus, it requires a two-thirds vote for final passage.

Public Necessity Statement

Article I, s. 24(c) of the State Constitution requires a public necessity statement for a newly created or expanded public record or public meeting exemption. This bill creates a new public record exemption and includes a public necessity statement that supports the exemption. The exemption may not be broader than necessary to accomplish the stated purpose of the law.

The bill provides a statement of public necessity for the current and prospective clients of the limited purpose ITCRO. No findings, however, are provided to support the public necessity statement for exempting personal identifying information appearing in an application or a new or renewal registration of a limited purpose ITCRO. Similarly, no findings are provided to support holding confidential and exempt from public disclosure the personal identifying information appearing in records relating to an OFR report or investigation of a limited purpose ITCRO. The findings provided for holding confidential and exempt the names and personal identifying information of clients and prospective

clients support their nondisclosure if contained in the foregoing applications, registrations, records, reports, or investigations.

C. Trust Funds Restrictions:

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 creates section 663.097 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 Committee on January 26, 2016:
The CS references the linked bill, SB 1106.

B. Amendments:

None.

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/26/2016	.	
	.	
	.	
	.	

The Committee on Banking and Insurance (Simmons) recommended the following:

Senate Amendment

Delete line 156
and insert:
SB 1106 or similar legislation takes effect, if such legislation

By Senator Flores

37-01350-16 20161094__

A bill to be entitled

An act relating to public records; creating s. 663.097, F.S.; defining terms; providing an exemption from public records requirements for certain information held by the Office of Financial Regulation relating to a limited purpose international trust company representative office; authorizing the release of certain confidential and exempt information by the office; authorizing the publication of certain information; providing a criminal penalty for willful disclosure; providing for future legislative review and repeal of the exemption; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Section 663.097, Florida Statutes, is created to read:

663.097 Public records exemption.—

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

(a) "Reports or investigations" means records submitted to or prepared by the office as part of the office's duties performed pursuant to s. 663.045, s. 663.046, or s. 663.09.

(b) "Working papers" means the records of the procedure followed, the tests performed, the information obtained, and the conclusions reached in an investigation under s. 663.045, s. 663.046, or s. 663.09. The term also includes books and records.

(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 appearing in

37-01350-16 20161094__

records relating to an application, or a new or renewal registration, of a limited purpose international trust company representative office.

(b) Any personal identifying information appearing in records relating to an investigation of a limited purpose international trust company representative office.

(c) Any personal identifying information appearing in reports or investigations of a limited purpose international trust company representative office, including working papers.

(d) Any portion of a list of names of the existing or prospective clients of an affiliated international trust company.

(e) Information received by the office from a person from another state or nation or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or nation 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 limited purpose international trust company representative office that is the subject of a report or investigation. The authorized representative or representatives shall be identified in a resolution or by written consent of the board of directors if the limited purpose international trust company representative office is a corporation, or of the managers if the limited purpose international trust company representative office is a limited liability company.

(b) To a fidelity insurance company or liability insurer,

upon written consent of the limited purpose international trust company representative office's board of directors if a corporation, or its managers if a limited liability company.

(c) To an independent auditor, upon written consent of the limited purpose international trust company representative office's board of directors if a corporation, or its managers if a limited liability company.

(d) To a liquidator, receiver, or conservator for a limited purpose international trust company representative office if a liquidator, receiver, or conservator is appointed. However, any portion of the information which discloses the identity of a current or prospective client of an affiliated international trust company must be redacted by the office before releasing such portion to the liquidator, receiver, or conservator.

(e) To any other state, federal, or foreign agency responsible for the regulation or supervision of limited purpose international trust company representative offices or an affiliated international trust company.

(f) To a law enforcement agency in the furtherance of the agency's official duties and responsibilities.

(g) To the appropriate law enforcement or prosecutorial agency for the purpose of reporting any suspected criminal activity.

(h) 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 such records or information, except in a case involving the investigation of charges against a public official subject to impeachment or removal, in which case 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) A report required by federal law.

(b) The name of the limited purpose international trust company representative office or any affiliated international trust company and the name and address of the directors, managers, officers, or registered agent of the limited purpose international trust company representative office or any affiliated international trust company.

(5) PENALTY.—A person who willfully 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 shall stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity to exempt from public records requirements any personal identifying information appearing in records relating to an application, or a new or renewal registration, of a limited purpose international trust company representative office; any personal identifying information appearing in records relating to an investigation of a limited purpose international trust company representative office; any personal identifying information appearing in reports or investigations

by the Office of Financial Regulation of a limited purpose international trust company representative office, including working papers; and any portion of a list of names of the existing or prospective clients of an affiliated international trust company.

(2) The Legislature finds that if financial information and lists of names of clients or prospective clients of affiliated international trust companies are available for public access, the personal and financial safety of the clients, the prospective clients, and their family members who are the subject of the information will be jeopardized. Families with high net worth are frequently the targets of criminal predators seeking access to their assets. It is important that the exposure of such clients or prospective clients and their family members to threats of extortion, kidnapping, and other crimes not be increased. Placing family names and their related private business records and methodologies into the public domain would increase the risk that a family would become the target of criminal activity. The Legislature further finds this is especially important because many of the clients and prospective clients of affiliated international trust companies reside in or frequently travel to countries in which kidnapping and extortion are significant risks and public corruption impedes the rule of law.

(3) The Legislature further finds that it is a public necessity to exempt from public records requirements information received by the office from a person from another state or nation or the Federal Government which is otherwise confidential or exempt pursuant to the laws of that state or nation or

pursuant to federal law. The Legislature finds that maintaining the confidentiality of the information shared with the office by those persons is necessary to protect the sensitive nature of the information and to facilitate the sharing of such information for the office's effective and efficient performance of its duties.

Section 3. This act shall take effect on the same date that SB ____ or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 13, 2016

I respectfully request that **Senate Bill #1094**, relating to Public Records / Limited Purpose International Trust Company, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Anitere Flores

Senator Anitere Flores
Florida Senate, District 37

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/2016
Meeting Date

SB 1094
Bill Number (if applicable)

Topic PUBLIC RECORDS EXEMPTION INTERNATIONAL TRUST COMPANY REP OFFICE
Amendment Barcode (if applicable)

Name SLATER BAILISS

Job Title

Address 215 S. MONROE ST #602
Street

Phone 850 222 8900

TALLAHASSEE FL 32301
City *State* *Zip*

Email subscardena@gunster.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing THE FLORIDA ASSOCIATION OF ADMINISTRATORS

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/25/16
Meeting Date

1094
Bill Number (if applicable)

Topic Public Records Exemption For SB 1106

Amendment Barcode (if applicable)

Name Raquel A. Rodriguez

Job Title AHorney

Address 200 S. Biscayne Blvd., Suite 2600 Phone 305-704-3994
Street

MIAMI FL 33149 Email rrodriguez@mcdonaldhopkins.com
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Florida International Administrators Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/16
Meeting Date

SB 1094
Bill Number (if applicable)

Topic INTERNATIONA TRUST COMPANIES PUBLIC RECORD

Amendment Barcode (if applicable)

Name ERNESTO MAIRHOFER

Job Title DIRECTOR

Address 701 BRICKELL AVE SUITE 2600
Street

Phone 305 5770233

MIAMI FL 33149
City *State* *Zip*

Email emeirhofer@citco.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing CITCO CORPORATE SERVICES INC

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/26/2016
Meeting Date

SB 1094
Bill Number (if applicable)

Topic LIMITED PURPOSE NT'L TRUST CO. - PUBLIC RECORD

Amendment Barcode (if applicable)

Name JOHN RYAN

Job Title PRESIDENT

Address 701 BRICKELL AVENUE, SUITE 1440
Street

Phone 305 728 - 8820

MIAMI, FL 33131
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing CISA LATAM LLC

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

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 632
INTRODUCER:	Senator Richter
SUBJECT:	Civil Remedies Against Insurers
DATE:	January 15, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Pre-meeting**
2.			JU	
3.			RC	

I. Summary:

SB 632 provides a 45 day window in which an insurer can act to avoid liability for failing to attempt to settle a claim in good faith. A third-party bad faith claim arises when an insurer fails in good faith to settle a third party's claim against the insured within policy limits and exposes the insured to liability in excess of his or her insurance coverage. A third-party claim can be brought by the insured, having been held liable for judgment in excess of policy limits by the third-party claimant.

This bill provides that before a third-party bad faith action for failure to settle a liability insurance claim may be filed, the claimant must provide the insurer a written notice of loss. To avoid bad faith liability for failing to attempt to settle a claim in good faith, the insurer must comply with a request for a disclosure statement and, within 45 days after receipt of the written notice of loss, offer to pay the claimant the lesser of the amount that the claimant is willing to accept in exchange for a full release of the insured from any liability arising from the incident reported in the written notice of loss or the limits of liability coverage applicable to the claimant's insurance claim. If the insurer complies with these conditions, the insurer does not violate the duty to attempt in good faith to settle the claim and is not liable for bad faith failure to settle.

II. Present Situation:

Obligations of Insurer to Insured

A liability insurer generally owes two major contractual duties to its insured in exchange for premium payments—the duty to indemnify and the duty to defend. The duty to indemnify refers to the insurer's obligation to issue payment either to the insured or a beneficiary on a valid claim. The duty to defend refers to the insurer's duty to provide a defense for the insured in court

against a third party with respect to a claim within the scope of the insurance contract.[1] The Florida Supreme Court explained the difference between indemnity policies and liability policies:

> Under indemnity policies, the insured defended the claim and the insurance company simply paid a claim against the insured after the claim was concluded. Under liability policies, however, insurance companies took on the obligation of defending the insured, which, in turn, made insureds dependent on the acts of the insurers; insurers had the power to settle and foreclose an insured's exposure or to refuse to settle and leave the insured exposed to liability in excess of policy limits.[2]

Historically, damages in actions for breaches of insurance contracts were limited to those contemplated by the parties when they entered into the contract.[3] As liability policies began to replace indemnity policies as the standard insurance policy form, courts recognized that insurers owed a duty to act in good faith towards their insureds.[4]

Common Law and Statutory Bad Faith

Florida courts for many years have recognized an additional duty that does not arise directly from the insurance contract, the common law duty of good faith on the part of an insurer to the insured in negotiating settlements with third-party claimants.[5] The common law rule is that a third-party beneficiary who is not a formal party to a contract may sue for damages sustained as the result of the acts of one of the parties to the contract.[6] This is known as a third-party claim of bad faith.

At common law, the insured cannot raise a bad faith claim against the insurer outside of the third-party claim context.[7] In 1982, the Legislature enacted s. 624.155, F.S. Section 624.155, F.S., recognizes a claim for bad faith against an insurer not only in the instance of settlement negotiations with a third party but also for an insured seeking payment from his or her own insurance company. This is known as a first-party claim of bad faith.

Section 624.155, F.S., provides that any party may bring a bad faith civil action against an insurer, and defines bad faith on the part of the insurer as:

- Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured with due regard for her or his interests;
- Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

[1] *See* 16 Williston on Contracts s. 49:103 (4th Ed.).
[2] *See State Farm Mutual Automobile Insurance Company v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).
[3] *Id.*
[4] *Id*.
[5] *See Auto. Mut. Indem. Co. v. Shaw*, 184 So. 852 (Fla. 1938).
[6] *See Thompson v. Commercial Union Insurance Company*, 250 So.2d 259 (Fla. 1971).
[7] *See Laforet*, 658 So.2d at 58-59.

- Except as to liability coverages, failing to promptly settle claims, when the obligation to settle the claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.[8]

In order to bring a bad faith claim under the statute, a plaintiff must first give the insurer 60 days written notice of the alleged violation.[9] The insurer has 60 days after the required notice is filed to pay the damages or correct the circumstances giving rise to the violation.[10] Because first-party claims are only statutory, that cause of action does not exist until the 60-day cure period provided in the statute expires without payment by the insurer.[11] Third-party claims, on the other hand, exist both in statute and at common law, so the insurer cannot guarantee avoidance of a bad faith claim by curing within the statutory period.[12]

In interpreting what it means for an insurer to act fairly toward its insured, Florida courts have held that when the insured's liability is clear and an excess judgment is likely due to the extent of the resulting damage, the insurer has an affirmative duty to initiate settlement negotiations.[13] If a settlement is not reached, the insurer has the burden of showing that there was no realistic possibility of settlement within policy limits.[14] Failure to settle on its own, however, does not mean that an insurer acts in bad faith. Negligent failure to settle does not rise to the level of bad faith. Negligence may be considered by the jury because it is relevant to the question of bad faith but a cause of action based solely on negligence is not allowed.[15]

Third-Party Claims of Bad Faith

A third-party bad faith claim arises when an insurer fails in good faith to settle a third party's claim against the insured within policy limits and exposes the insured to liability in excess of his or her insurance coverage.[16] The Florida Supreme Court has described an insurer's duty to its insureds:

> An insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business. For when the insured has surrendered to the insurer all control over the handling of the claim, including all decisions with regard to litigation and settlement, then the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured. This good faith duty obligates the insurer to advise the insured of settlement opportunities, to advise as to the probable

[8] *See* s. 624.155(1)(b)1.-3., F.S.
[9] *See* s. 624.155(3)(a), F.S. The notice must be on a form approved by the Department of Financial Services. If the Department returns the notice for lack of specificity, the day period does not begin until a proper notice is filed. The notice form can be found at https://apps.fldfs.com/CivilRemedy/ (last accessed on January 11, 2016).
[10] *See* s. 624.155(3)(d), F.S.
[11] *See Talat Emterprises vv. Aetna Casualty and Surety Company*, 753 So.2d 1278, 1284 (Fla. 2000).
[12] *See Macola v. Government Employees Insurance Company*, 953 So.2d 451 (Fla. 2006).
[13] *See Powell v. Prudential Property and Casualty Insurance Company*, 584 So.2d 12, 14 (Fla. 3d DCA 1991).
[14] *Id*.
[15] *See DeLaune v. Liberty Mutual Insurance Company*, 314 So.2d 601,603 (Fla. 4th DCA 1975).
[16] *See Opperman v. Nationwide Mutual Fire Insurance Company*, 515 So.2d 263, 265 (Fla. 5th DCA 1987).

> outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid same. The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so. Because the duty of good faith involves diligence and care in the investigation and evaluation of the claim against the insured, negligence is relevant to the question of good faith. The question of failure to act in good faith with due regard for the interests of the insured is for the jury.[17]

In light of this heightened duty on the part of the insurer, Florida courts focus on the actions of the insurer, not the claimant.[18] Whether an insurer acted in bad faith is determined by the totality of the circumstances:

> In Florida, the question of whether an insurer has acted in bad faith in handling claims against the insured is determined under the totality of the circumstances standard. Each case is determined on its own facts and ordinarily the question of failure to act in good faith with due regard for the interests of the insured is for the jury.[19]

The focus in a bad faith case is on the conduct of the insurer but the conduct of the claimant is relevant to whether there was a realistic opportunity for settlement.[20] A court, for example, will look at the terms of a demand for settlement to determine if the insurer was given a reasonable amount of time to investigate the claim and make a decision whether settlement would be appropriate under the circumstances. One court held that dismissal of a bad faith claim was proper where the settlement demand in question gave a 10-day window, pointing out that "[i]n view of the short space of time between the accident and institution of suit, the provision of the offer to settle limiting acceptance to 10 days made it virtually impossible to make an intelligent acceptance."[21] Although in this particular circumstance the court found that 10 days was not enough, it is not clear exactly what time period or other conditions for acceptance would be permissible, because courts look at the facts on a case-by-case basis and the current statute is silent on this point.

In *Berges*, dissenting justices expressed concern that there "is a strategy which consists of setting artificial deadlines for claims payments and the withdrawal of settlement offers when the artificial deadline is not met."[22] It was argued that it is a "common practice for a party contemplating litigation to submit a settlement offer that remains outstanding for only a finite period and that a person injured by a policyholder may set any deadlines he desires—even an

[17] *Boston Old Colony Insurance Company v. Gutierrez*, 386 So.2d 783, 785 (Fla. 1980)(internal citations omitted).
[18] *See Berges v. Infinity Insurance Company*, 896 So.2d 665, 677 (Fla. 2005)(explaining that "the focus in a bad faith case is not on the actions of the claimant but rather on those of the insurer in fulfilling its obligations to the insured").
[19] *See Berges*, 896 So.2d at 680 (internal quotations and citations omitted).
[20] *See Barry v. GEICO General Insurance Company*, 938 So.2d 613, 618 (Fla. 4th DCA 2006).
[21] *DeLaune v. Liberty Mut. Ins. Co.*, 314 So.2d 601, 603 (Fla. 4th DCA 1975).
[22] *Berges*, 896 So.2d at 685 (Wells, J., dissenting).

arbitrary or unreasonable one."[23] Justice Wells concluded that set time periods in which all insurers must make decisions on claims and issue payments are needed.[24]

The majority in *Berges* held that courts must look to the totality of the circumstances. "The question of bad faith in this case extends to [the insurer's] entire conduct in the handling of the claim, including the acts or omissions [of the insurer] in failing to ensure payment of the policy limits within the time demands."[25] Another court argued that setting a "minimum amount of time before any finding of bad faith is possible runs counter to the analysis of ordinary care and prudent business practice… Juries are empaneled to apply the appropriate criteria to the particular facts of a given situation and to decide whether the insurer acted prudently."[26]

Disclosure Statements

Section 627.4137, F.S., requires an insurer to provide, within 30 days of the written request of the claimant, a statement, under oath, of a corporate officer or the insurer's claims manager or superintendent setting forth the following information with regard to each known policy of insurance, including excess or umbrella insurance:

- The name of the insurer.
- The name of each insured.
- The limits of the liability coverage.
- A statement of any policy or coverage defense which such insurer reasonably believes is available to such insurer at the time of filing such statement.
- A copy of the policy.

In addition, the insured, or her or his insurance agent, upon written request of the claimant or the claimant's attorney, must disclose the name and coverage of each known insurer to the claimant and shall forward such request for information on all affected insurers. The insurer shall then supply the information required in this subsection to the claimant within 30 days of receipt of such request. Section 627.4137(2), F.S., requires that the disclosure statement be amended immediately upon discovery of facts calling for an amendment to such statement.

III. Effect of Proposed Changes:

This bill provides that, as a condition precedent to a third-party statutory or common-law bad faith action for failure to settle a liability insurance claim, the insured, the claimant, or anyone on behalf of the insured or the claimant must provide the insurer a written notice of loss. This bill does not change the requirements for first-party bad faith claims.

If the insurer complies with a request for a disclosure statement as described in s. 627.4137, F.S., and, within 45 days after receipt of the written notice of loss, offers to pay the claimant the lesser of the limits of liability coverage applicable to the claimant's insurance claim or the amount that the claimant is willing to accept in exchange for a full release of the insured from any liability

[23] *Id.* at 692 (Cantero, J., dissenting).
[24] *Id*. at 686 (Wells, J., dissenting).
[25] *Berges*, 896 So.2d at 627.
[26] *Snowden ex. rel. Estate of Snowden v. Lumbermans Mutual Casualty Company*, 358 F.Supp.2d 1125, 1129 (N.D. Fla. 2003).

arising from the incident reported in the written notice loss, the insurer does not violate the duty to attempt in good faith to settle the claim and is not liable for bad faith failure to settle.

Current law provides that bad faith is determined based on the totality of the circumstances. This bill would provide that an insurer is not liable for bad faith failure to settle if the insurer complies with the provisions of this bill.

This bill is effective July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The private sector fiscal impact of this bill is indeterminate. This bill will create a 45 day window for insurers to avoid bad faith claims.

C. Government Sector Impact:

The government sector fiscal impact is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 624.155 of the Florida Statutes.

This bill reenacts section 766.1185 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 Richter

23-00002-16 2016632__

A bill to be entitled

An act relating to civil remedies against insurers; amending s. 624.155, F.S.; requiring an insured, a claimant, or a person acting on behalf of an insured or a claimant to provide an insurer with written notice of loss as a condition precedent to bringing a statutory or common-law action for a third-party bad faith action for failure to settle an insurance claim; providing that an insurer is not liable for such claim if certain conditions are met; reenacting s. 766.1185(3), F.S., relating to bad faith actions, to incorporate the amendment made to s. 624.155, F.S., in a reference thereto; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 624.155, Florida Statutes, is amended, and subsection (10) is added to that section, to read:

624.155 Civil remedy.—

(3)(a) Except as provided in subsection (10), as a condition precedent to bringing an action under this section, the department and the authorized insurer must have been given 60 days' written notice of the violation. If the department returns a notice for lack of specificity, the 60-day time period does ~~shall~~ not begin until a proper notice is filed.

(10) As a condition precedent to bringing a third-party statutory or common-law bad faith action for failure to settle a liability insurance claim, the insured, the claimant, or any person acting on behalf of the insured or the claimant must have provided the insurer with a written notice of loss. An insurer does not violate the duty to attempt in good faith to settle the claim and is not liable for a bad faith failure to settle under this section or common law if the insurer:

(a) Complies with a request for a disclosure statement as described in s. 627.4137.

(b) Offers, within 45 days after receipt of the written notice of loss, to pay the claimant the lesser of the amount that the claimant is willing to accept or the limits of liability coverage applicable to the claimant's insurance claim in exchange for a full release of the insured from any liability arising from the incident reported in the written notice of loss.

Section 2. For the purpose of incorporating the amendment made by this act to section 624.155, Florida Statutes, in a reference thereto, subsection (3) of section 766.1185, Florida Statutes, is reenacted to read:

766.1185 Bad faith actions.—In all actions for bad faith against a medical malpractice insurer relating to professional liability insurance coverage for medical negligence, and in determining whether the insurer could and should have settled the claim within the policy limits had it acted fairly and honestly towards its insured with due regard for her or his interest, whether under statute or common law:

(3) The provisions of s. 624.155 shall be applicable in all cases brought pursuant to that section unless specifically controlled by this section.

Section 3. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Lizbeth Benacquisto, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: November 5, 2015

I respectfully request that **Senate Bill #632**, relating to Civil Remedies Against Insurers, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Garrett Richter
Florida Senate, District 23

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR DOROTHY L. HUKILL
8th District

COMMITTEES:
Finance and Tax, *Chair*
Communications, Energy, and Public Utilities, *Vice Chair*
Appropriations
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Banking and Insurance
Fiscal Policy

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

January 25, 2016

The Honorable Lizbeth Benacquisto
Banking & Insurance Committee, Chair
320 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Re: Request for Excusal from Committee Meeting

Dear Chairwoman Benacquisto:

Please excuse me from the Banking and Insurance Committee on January 26, 2016 as I am out due to illness.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Dorothy L. Hukill

Dorothy L. Hukill
State Senator, District 08

cc: James Knudson, Staff Director of the Banking and Insurance Committee
Sheri Green, Administrative Assistant of the Banking and Insurance Committee

REPLY TO:
❒ 209 Dunlawton Avenue, Unit 17, Port Orange, Florida 32127 (386) 304-7630 FAX: (888) 263-3818
❒ Ocala City Hall, 110 SE Watula Avenue, 3rd Floor, Ocala, Florida 34471 (352) 694-0160

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

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore