Insurance & Banking Subcommittee

Monday, February 1, 2016
12:00 PM
Sumner Hall (404 HOB)

MEETING PACKET

Steve Crisafulli
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Insurance & Banking Subcommittee

Start Date and Time:	Monday, February 01, 2016 12:00 pm
End Date and Time:	Monday, February 01, 2016 02:30 pm
Location:	Sumner Hall (404 HOB)
Duration:	2.50 hrs

Consideration of the following bill(s):

HB 363 Health Insurance For Opioids by Nuñez
CS/HB 379 Transfers of Structured Settlement Payment Rights by Civil Justice Subcommittee, Santiago
HB 543 Small Group Health Insurance by Stark
HB 783 Unclaimed Property by Trumbull
HB 897 Service of Process on Financial Institutions by Stone
HB 951 Health Plan Regulatory Administration by Cummings
HB 965 Firesafety by Harrison
HB 1317 Interstate Purchase of Health Insurance by Miller
HB 1327 Sinkhole Insurance by Ingoglia
HB 1425 Consumer Finance by Fant

Consideration of the following proposed committee substitute(s):

PCS for HB 583 -- Provision of Pharmaceutical Services
PCS for HB 713 -- Consumer Debt Collection
PCS for HB 879 -- Organization of the Department of Financial Services
PCS for HB 1303 -- Life Insurance Coverage for Funeral Expenses
PCS for HB 1383 -- Limited Purpose International Trust Company Representative Offices

Pursuant to rule 7.12, the filing deadline for amendments to bills on the agenda by a member who is not a member of the committee or subcommittee considering the bill is 6:00 p.m., Friday, January 29, 2016.

By request of the Chair, all Insurance & Banking Subcommittee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Friday, January 29, 2016

NOTICE FINALIZED on 01/28/2016 4:24PM by McCloskey.Michele

The Florida House of Representatives

Regulatory Affairs Committee

Insurance & Banking Subcommittee

Steve Crisafulli
Speaker

John Wood
Chair

AGENDA

February 1, 2016
404 House Office Building
12:00 PM – 2:30 PM

I. Prayer and Pledge of Allegiance

II. Call to Order & Roll Call

III. Consideration of the following bill(s):

A. HB 363 Health Insurance For Opioids by Nuñez

B. CS/HB 379 Transfers of Structured Settlement Payment Rights by Civil Justice Subcommittee, Santiago

C. HB 543 Small Group Health Insurance by Stark

D. HB 783 Unclaimed Property by Trumbull

E. HB 897 Service of Process on Financial Institutions by Stone

F. HB 951 Health Plan Regulatory Administration by Cummings

G. HB 965 Firesafety by Harrison

H. HB 1317 Interstate Purchase of Health Insurance by Miller

I. HB 1327 Sinkhole Insurance by Ingoglia

303 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300
(850) 717-4871 Fax: (850) 413-0419

J. HB 1425 Consumer Finance by Fant

K. PCS for HB 583 Provision of Pharmaceutical Services by Insurance & Banking Subcommittee

L. PCS for HB 713 Consumer Debt Collection by Insurance & Banking Subcommittee

M. PCS for HB 879 Organization of the Department of Financial Services by Insurance & Banking Subcommittee

N. PCS for HB 1303 Life Insurance Coverage for Funeral Expenses by Insurance & Banking Subcommittee

O. PCS for HB 1383 Limited Purpose International Trust Company Representative Offices by Insurance & Banking Subcommittee

IV. Adjournment

HB 363

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 363 Health Insurance Coverage For Opioids
SPONSOR(S): Nuñez
TIED BILLS: **IDEN./SIM. BILLS:** SB 422

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 1 N	McElroy	Poche
2) Insurance & Banking Subcommittee		Peterson KP	Luczynski MJ
3) Appropriations Committee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

Deaths from drug overdose have steadily increased over the past few decades and are the leading cause of accidental deaths in the United States. Every day in the United States,120 people die as a result of drug overdose, and another 6,748 are treated in emergency departments for the misuse or abuse of drugs. The vast majority of these deaths and emergency department visits involve an overdose related to opioid analgesic drug products (opioids), which are narcotic pain relievers derived from the opium poppy or its synthetic analogues.

Opioids can be abused in numerous ways, such as by swallowing, snorting, smoking, or injecting. These delivery methods create a more rapid onset of the effects of the opioid than intended by the manufacturer and a greater euphoria. Abuse-deterrent opioids are formulated to deter abuse by making product alteration more difficult (crush resistant) or by making the altered product less attractive or rewarding (crushing renders the drug essentially ineffective).

HB 363 allows a health insurance policy that provides coverage for opioids to impose a prior authorization requirement for an abuse-deterrent opioid only if the policy requires prior authorization for opioids without an abuse-deterrence labeling claim. The bill also prohibits a policy from requiring the use of an opioid without an abuse-deterrent labeling claim before providing coverage for an abuse-deterrent opioid.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of January 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Opioids

The drug overdose death rate has more than doubled from 1999 through 2013 and has now become the leading cause of accidental deaths in the United States.[1] In 2013, there were 43,982 drug overdose deaths in the United States, of which 22,767, or 51.8 percent, were related to pharmaceuticals.[2] The majority of the pharmaceutical-related deaths (16,235, or 71.3 percent) involved opioid analgesic drug products (opioids).[3]

Opioids also play a prominent role in drug overdose deaths in Florida. In 2014, there were 8,587 drug-related deaths in the state.[4] Opioids were listed as the cause of death in 2,922 cases and were present in an additional 3,098 cases.[5] The four most harmful drugs, found in more than 50 percent of the deaths in which drugs were present, were all opioids.[6]

Opioids are psychoactive substances derived from the opium poppy or their synthetic analogues.[7] They are commonly used as pain relievers to treat acute and chronic pain. An individual experiences pain as a result of a series of electrical and chemical exchanges among his or her peripheral nerves, spinal cord, and brain.[8] Opioid receptors occur naturally, and are distributed widely throughout the central nervous system and in peripheral sensory and autonomic nerves.[9] When an individual experiences pain, the body releases hormones, such as endorphins, which bind with targeted opioid receptors.[10] This disrupts the transmission of pain signals through the central nervous system and reduces the perception of pain.[11] Opioids function in the same way by binding to specific opioid receptors in the brain, spinal cord, and gastrointestinal tract, thereby reducing the perception of pain.[12] Opioids include:[13]

- Buprenorphine (Subutex, Suboxone)
- Codeine
- Fentanyl (Duragesic, Fentora)
- Heroin
- Hydrocodone (Vicodin, Lortab, Norco)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine

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[1] More deaths occur each year due to drug overdose than deaths caused by motor vehicle crashes. CENTERS FOR DISEASE CONTROL AND PREVENTION, *Prescription Drug Overdose Data*, http://www.cdc.gov/drugoverdose/data/overdose.html (last visited Jan. 23, 2016).
[2] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Prescription Drug Overdose Data*, http://www.cdc.gov/drugoverdose/data/overdose.html (last visited Jan. 23, 2016).
[3] *Id.*
[4] Florida Department of Law Enforcement, *Drugs Identified in Deceased Persons by Florida Medical Examiners 2014 Annual Report,* Sept. 2015, https://www.fdle.state.fl.us/Content/Medical-Examiners-Commission/Drugs-in-Deceased-Persons-Reports.aspx (last visited Jan. 23, 2016).
[5] *Id.* A decedent may have more than one drug listed as the cause of death.
[6] *Id.* Heroin (91.3 percent), Fentanyl (73.8 percent), Methadone (63.2 percent), Morphine (59.1 percent).
[7] WORLD HEALTH ORGANIZATION, *Information Sheet on Opioid Overdose* (Nov. 2014), http://www.who.int/substance_abuse/information-sheet/en/ (last visited Jan. 23, 2016).
[8] RIVERSIDE, *How you feel pain,* http://www.riversideonline.com/health_reference/Nervous-System/PN00017.cfm (last visited Jan. 23, 2016).
[9] Gjermund Henriksen, Frode Willoch, *Imaging of Opioid Receptors in the Central Nervous System,* Brain (May 2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2367693/ (last visited Jan. 23, 2016).
[10] *Id.*
[11] *Id.*
[12] Substance Abuse and Mental Health Services Administration *SAMHSA Opioid Overdose Toolkit: Facts for Community Members* (2014), http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742 (last visited Jan. 23, 2016).
[13] *Supra* note 4.

- Methadone
- Morphine
- Oxycodone (OxyContin, Percodan, Percocet)
- Oxymorphone
- Tramadol

Opioid formulations are classified as either short-acting opioids or long-acting opioids, which relate to the onset and duration of the effects of the drug in the body. Short-acting opioids are typically prescribed for transient pain types, such as acute, breakthrough, or chronic intermittent pain and include the immediate-release formulation of various opioids.[14] The effects of an immediate-release opioid begin shortly after ingestion and generally last between three to four hours. Long-acting opioids are typically prescribed for chronic pain. They are designed to release the drug gradually into the blood stream and include the extended-release formulation of various opioids.[15] The effects of an extended-release opioid generally last between eight to twelve hours with some formulations of long-acting opioids having an effect for up to seventy-two hours.[16]

Opioid Abuse and Misuse

The abuse and misuse of opioids is a serious and growing public health concern. In the United States:

- Approximately 4.5 million individuals use prescription pain medications for nonmedical purposes.[17]
- In 2011, approximately 1.4 million emergency departments (ED) visits involved nonmedical use of pharmaceuticals.[18]
- Every day, 114 people die as a result of drug overdose, and approximately 6,748 are treated in the ED for the misuse or abuse of drugs.[19]
- Nearly nine out of ten poisoning deaths are caused by drugs.[20]
- In 2007, prescription opioid abuse costs were about $55.7 billion.[21]

Opioids can be abused and misused in a variety of ways. For example, an abuser may swallow a greater quantity of the unaltered drug than what is prescribed. This typically occurs with extended-release opioids. Also, abusers may crush extended-release opioids and ingest the drug in a number of ways, including:[22]

- Swallowing;

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[14] Charles E. Argoff and Daniel I. Silverstein, *A Comparison of Long and Short-Acting Opioids for the Treatment of Chronic Noncancer Pain: Tailoring Therapy to Meet the Patient Need*, Mayo Clin Proc. (July 2009), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704132/ (last visited Jan. 23, 2016).

[15] *Id.*

[16] *Id.*

[17] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *The NSDUH Report: Substance and Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings*, Sept. 4, 2014, *available at* http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http percent3A percent2F percent2Fstore.samhsa.gov percent2Fshin percent2Fcontent percent2FNSDUH14-0904 percent2FNSDUH14-0904.pdf&ei=WwQDVY2ZMsuXNobrgNAH&usg=AFQjCNEFZtjCu4cxzFBucykETY7MMsY2Fg (last visited Jan. 23, 2016).

[18] Centers for Disease Control, *Prescription Drug Overdose in the United States: Factsheet*, *available at* http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&ved=0CDYQFjAGahUKEwjWueOGz_fIAhVImx4KHdz1CtY&url=http percent3A percent2F percent2Fwww.mayorsinnovation.org percent2Fimages percent2Fuploads percent2Fpdf percent2F1_-_Prescription_Drug_Overdose_in_the_United_States.pdf&usg=AFQjCNG4txIr2GiqmkMxlcpalgqZ6MguNA (last visited Jan. 23, 2016).

[19] *Id.*

[20] *Id.*

[21] *Id.* Of this amount, 46 percent was attributable to workplace costs (e.g., lost productivity), 45 percent to healthcare costs (e.g., abuse treatment), and 9 percent to criminal justice costs.

[22] U.S. Food and Drug Administration, *Draft Guidance for Industry: Abuse-Deterrent Opioids-Evaluation and Labeling*, April 2015, *available at* http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CB4QFjAA&url=http percent3A percent2F percent2Fwww.fda.gov percent2Fdownloads percent2Fdrugs percent2Fguidancecomplianceregulatoryinformation percent2Fguidances percent2Fucm334743.pdf&ei=HykDVaWHDpLRggTIgoT4Cg&usg=AFQjCNHvX1Wg3qdmw6C3Jz97t3uIJ5-bxw&bvm=bv.88198703,d.eXY (last viewed Jan. 23, 2016).

- Snorting;
- Smoking; or
- Dissolving and injecting.

Opioids are commonly abused for their euphoric effect.[23] Extended-release opioids hold a greater attraction for abusers than immediate-release opioids because of their higher concentrations of the drug.[24] When extended-release opioids are altered, the higher concentrations of the drug are immediately absorbed into the bloodstream as contrasted with the gradual release and absorption of the drug as originally designed. This creates a more rapid onset of the effects of the opioids than the manufacturer intended and a greater euphoria.[25] This is the effect the abusers seek; however, this commonly can lead to overdose and death.

Continued use or abuse of opioids can lead to the development of tolerance and psychological and physical dependence.[26] This dependence is characterized by a strong desire to take opioids; impaired control over opioid use; persistent opioid use despite harmful consequences; a higher priority given to opioid use than to other activities and obligations; and a physical withdrawal reaction when opioids are discontinued.[27] This issue is widespread: an estimated 15 million people worldwide suffer from opioid dependence.[28]

Abuse-Deterrent Opioids

Abuse-deterrent opioids are formulated to deter abuse and misuse of the drug.[29] The goal of abuse-deterrent opioids is to limit access to or attractiveness of the active ingredient that is highly attractive to abusers, while still assuring the safe and effective release of the medication for patients.[30]

In 2013, the Food and Drug Administration (FDA) released draft guidance to assist the pharmaceutical industry in developing new formulations of opioid drugs with abuse-deterrent properties. The document provides guidance on the studies that should be conducted to demonstrate that a given formulation has abuse-deterrent properties, how the studies will be evaluated, and what labeling claims may be approved based on the results of the studies.[31]

The FDA guidance provides that abuse-deterrent formulations are categorized into one of the following groups:[32]

- **Physical/Chemical barriers** – Physical barriers can prevent chewing, crushing, cutting, grating, or grinding. Chemical barriers can resist extraction of the opioid using common solvents like water, alcohol, or other organic solvents. Physical and chemical barriers can change the physical form of an oral drug rendering it less amenable to abuse.
- **Agonist/Antagonist combinations** – An opioid antagonist can be added to interfere with, reduce, or defeat the euphoria associated with abuse. The antagonist can be sequestered and released only upon manipulation of the product. For example, a drug product may be formulated

[23] Opioids affect the regions of the brain involved with pleasure and reward and can thereby create a euphoric effect. National Institute on Drug Abuse, *How Do Opioids Affect the Brain and Body?*, http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/how-do-opioids-affect-brain-body (last visited Jan. 23, 2016).
[24] Robin Moorman-Li, Carol Motycka, et al., *A Review of Abuse-Deterrent Opioids for Chronic Nonmalignant Pain*, P.T. (July 2012), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411218/
(last visited Jan. 23, 2016).
[25] *Id.*
[26] *Supra* note 9.
[27] *Supra* note 7.
[28] *Id.*
[29] The National Addictions Vigilance Intervention and Prevention Program (NAVIPPRO) database was created to track drugs of abuse, their current popularity and their preferred method of use by abusers. Pharmaceutical companies can review this database to determine the drugs of abuse the most concern and to identify the routes of delivery that new formulations should specifically strive to deter. *Supra* note 24.
[30] *Id.*
[31] *Supra* note 22.
[32] *Id.*

such that the substance that acts as an antagonist is not clinically active when the product is swallowed but becomes active if the product is crushed and injected or snorted.

- **Aversion** – Substances can be combined to produce an unpleasant effect if the dosage form is manipulated prior to ingestion or a higher dosage than directed is used.
- **Delivery System** – Certain drug release designs or the method of drug delivery can offer resistance to abuse. For example, a sustained-release depot injectable formulation that is administered intramuscularly or a subcutaneous implant can be more difficult to manipulate.
- **Prodrug** – A prodrug that lacks opioid activity until transformed in the gastrointestinal tract can be unattractive for intravenous injection or intranasal routes of abuse.
- **Combination** – Two or more of the above methods can be combined to deter abuse.
- **Novel approaches** – This category encompasses novel approaches or technologies that are not captured in the previous categories.

Abuse Deterrence Studies and Labeling

The FDA recommends pre-market and post-market studies which evaluate the known routes of abuse of opioids and anticipate new routes that could develop due to the development of abuse-deterrent opioids. These studies fall into four categories:[33]

- **Category 1 – Laboratory-based in vitro manipulation and extraction studies**. The goal of laboratory-based studies is to evaluate the ease with which the potentially abuse-deterrent properties of a formulation can be defeated or compromised. This information should be used when designing Category 2 and Category 3 studies.
- **Category 2 – Pharmacokinetic studies**. The goal of the clinical pharmacokinetic studies is to understand the in vitro properties of the formulation by comparing the pharmacokinetic profiles of the manipulated formulation with the intact formulation and with manipulated and intact formulations of the comparator drugs through one or more routes of administration.
- **Category 3 – Clinical abuse potential studies**. The goal of clinical studies of abuse potential is to assess the impact of potentially abuse-deterrent properties.
- **Category 4 – Post-market**. The goal of post-market studies is to determine whether the marketing of a product with abuse-deterrent properties results in meaningful reductions in abuse, misuse, and related adverse clinical outcomes, including addiction, overdose, and death in the post-approval setting.

Abuse-deterrent labeling is important to inform health care professionals, the patient community, and the public about a product's abuse potential.[34] The FDA encourages labeling that sets forth the results of in vitro, pharmacokinetic, clinical abuse potential, and formal post-market studies and that appropriately characterizes the abuse-deterrent properties of a product.[35] Category 1 studies should be described in general terms to avoid creating a road map for defeating the product's abuse-deterrent properties.[36] However, the design, conduct, and results of Category 2 and 3 studies should be described in sufficient detail to support clear labeling regarding a product's abuse-deterrent properties.[37]

Health Insurer Prior Authorization

Insurers use cost containment strategies to manage medical and drug spending and utilization. For example, plans may place utilization management requirements on the use of certain drugs on their formulary, such as requiring enrollees to obtain prior authorization from their plan before being able to fill a prescription; requiring enrollees to try a preferred drug to treat a medical condition before allowing

[33] *Id.*
[34] *Id.*
[35] *Id*
[36] *Id.*
[37] *Id.*

them to obtain an alternate drug for that condition; or limiting the quantity of drugs that the plan will cover during a certain period of time.[38]

Prior authorization is a requirement for a health care provider to obtain approval from an insurer before a patient may receive a specified diagnostic or therapeutic treatment or specified prescription drugs.[39] A preferred drug list is an established list of one or more prescription drugs within a therapeutic class deemed clinically equivalent and cost effective.[40] In order to obtain another drug within the therapeutic class, not part of the preferred drug list, prior authorization is required.[41]

Health insurers are increasingly turning to step therapy (or "fail first") policies in pharmacy benefit design.[42] This designation requires an insured to try one drug first to treat his or her medical condition before the insurer will cover another drug for that condition.[43] For example, if Drug A and Drug B both treat a medical condition, a plan may require doctors to prescribe Drug A first. If Drug A does not work for a beneficiary, then the plan will cover Drug B.

Effect of the Proposed Changes

HB 363 allows a health insurance policy that provides coverage for opioids to impose a prior authorization requirement for an abuse-deterrent opioid only if the policy imposes the same prior authorization requirement for opioids without an abuse-deterrence labeling claim. The bill defines "abuse-deterrent opioid analgesic drug product" as a brand or generic opioid analgesic drug product approved by the U.S. Food and Drug Administration with an abuse-deterrence labeling claim that indicates the drug product is expected to deter abuse. The bill defines "opioid analgesic drug product" as a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions in immediate-release, extended-release, or long-acting form regardless of whether or not combined with other drug substances to form a single drug product or dosage form.

The bill prohibits a policy from requiring the use of an opioid without an abuse-deterrent labeling claim before providing coverage for an abuse-deterrent opioid. As a result, a physician may prescribe an abuse-deterrent opioid for a patient as an initial treatment, rather than waiting for a patient to fail in the use of a non-abuse deterrent opioid.

The bill provides an effective date of January 1, 2017.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.64194, F.S., relating to requirements for opioid coverage.
Section 2: Provides an effective date of January 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

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[38] POLICY MATTERS JOURNAL, Leah Krieger, *Prescription for Prior Authorizations: A Better Way*, (Fall 2014- Special Edition), http://www.policymattersjournal.org/krieger.html (last visited Jan. 23, 2016).
[39] AMERICAN MEDICAL ASSOCIATION, *Administrative Simplification and Fair Contracting*, http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/admin-simp-fair-contracting.page (last visited Jan. 23, 2016).
[40] National Conference of State Legislatures, *Health Cost Containment and Efficiencies, NCSL Briefs for State Legislators* (June 2010), *available at* http://www.ncsl.org/documents/health/IntroandBriefsCC-16.pdf (last visited Jan. 23, 2016).
[41] *Id.*
[42] Rahul K. Nayak and Steven D. Pearson, *The Ethics Of 'Fail First': Guidelines And Practical Scenarios For Step Therapy Coverage Policies*, Health Aff October 2014, vol. 33, no. 10, 1779-1785.
[43] *Id.*

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill creates requirements for health insurance policies that provide coverage for "opioid analgesic drug products." It is unclear whether the requirements are triggered if a policy only provides coverage for an "opioid analgesic drug product without an abuse-deterrence labeling claim." If that is the case, the bill appears to require the policy to also provide coverage for an "abuse-deterrent opioid analgesic drug product" which may result in higher costs for insurers. Additionally, insurers may pay higher costs for abuse-deterrent opioids prescribed by a physician as an initial treatment, rather than paying for lower cost opioids without an abuse-deterrence claim.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to health insurance coverage for
3 opioids; creating s. 627.64194, F.S.; defining terms;
4 providing that a health insurance policy that covers
5 opioid analgesic drug products may impose a prior
6 authorization requirement for an abuse-deterrent
7 opioid analgesic drug product only if the insurer
8 imposes the same requirement for each opioid analgesic
9 drug product without an abuse-deterrence labeling
10 claim; prohibiting such health insurance policy from
11 requiring use of an opioid analgesic drug product
12 without an abuse-deterrence labeling claim before
13 providing coverage for an abuse-deterrent opioid
14 analgesic drug product; providing an effective date.
15
16 WHEREAS, the Legislature finds that the abuse of opioids is
17 a serious problem that affects the health, social, and economic
18 welfare of this state, and
19 WHEREAS, the Legislature finds that an estimated 2.1
20 million people in the United States suffered from substance use
21 disorders related to prescription opioid pain relievers in 2012,
22 and
23 WHEREAS, the Legislature finds that the number of
24 unintentional overdose deaths from prescription pain relievers
25 has more than quadrupled since 1999, and
26 WHEREAS, the Legislature is convinced that it is imperative

27 for people suffering from pain to obtain the relief they need
28 while minimizing the potential for negative consequences, NOW,
29 THEREFORE,
30
31 Be It Enacted by the Legislature of the State of Florida:
32
33 Section 1. Section 627.64194, Florida Statutes, is created
34 to read:
35 627.64194 Requirements for opioid coverage.—
36 (1) DEFINITIONS.—As used in this section, the term:
37 (a) "Abuse-deterrent opioid analgesic drug product" means
38 a brand or generic opioid analgesic drug product approved by the
39 United States Food and Drug Administration with an abuse-
40 deterrence labeling claim that indicates the drug product is
41 expected to deter abuse.
42 (b) "Opioid analgesic drug product" means a drug product
43 in the opioid analgesic drug class prescribed to treat moderate
44 to severe pain or other conditions in immediate-release,
45 extended-release, or long-acting form regardless of whether or
46 not combined with other drug substances to form a single drug
47 product or dosage form.
48 (2) COVERAGE REQUIREMENTS.—A health insurance policy that
49 provides coverage for opioid analgesic drug products:
50 (a) May impose a prior authorization requirement for an
51 abuse-deterrent opioid analgesic drug product only if the policy
52 imposes the same prior authorization requirement for each opioid

53 analgesic drug product without an abuse-deterrence labeling
54 claim which is covered by the policy.
55 (b) May not require use of an opioid analgesic drug
56 product without an abuse-deterrence labeling claim before
57 providing coverage for an abuse-deterrent opioid analgesic drug
58 product.
59 Section 2. This act shall take effect January 1, 2017.

INSURANCE & BANKING SUBCOMMITTEE

HB 363 by Rep. Nuñez
HEALTH INSURANCE FOR OPIOIDS

AMENDMENT SUMMARY
February 1, 2016

Amendment 1 by Rep. Nuñez (Lines 49 - 57): clarifies that the new requirements apply only if the plan offers both abuse-deterrent opioid analgesics and opioid analgesic products that are not abuse-deterrent. A plan that does not offer abuse-deterrent opioid analgesic drug products would not be required to add those drugs as a result of the new requirement.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Nuñez offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 49-57 and insert:
7 provides coverage for abuse-deterrent opioid analgesic drug
8 products:
9 (a) May impose a prior authorization requirement for an
10 abuse-deterrent opioid analgesic drug product only if the policy
11 imposes the same prior authorization requirement for each opioid
12 analgesic drug product without an abuse-deterrence labeling
13 claim.
14 (b) May not require use of an opioid analgesic drug
15 product without an abuse-deterrence labeling claim before
16 authorizing the use of an abuse-deterrent opioid analgesic drug
17

18 ----------

19 **T I T L E A M E N D M E N T**

20 Remove lines 5-13 and insert:

21 abuse-deterrent opioid analgesic drug products may impose a
22 prior authorization requirement for an abuse-deterrent opioid
23 analgesic drug product only if the insurer imposes the same
24 requirement for each opioid analgesic drug product without an
25 abuse-deterrence labeling claim; prohibiting such health
26 insurance policy from requiring use of an opioid analgesic drug
27 product without an abuse-deterrence labeling claim before
28 authorizing use of an abuse-deterrent opioid

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 379 Transfers of Structured Settlement Payment Rights
SPONSOR(S): Civil Justice Subcommittee; Santiago
TIED BILLS: None **IDEN./SIM. BILLS:** CS/SB 458

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	12 Y, 0 N, As CS	King	Bond
2) Insurance & Banking Subcommittee		Lloyd	Luczynski
3) Judiciary Committee			

SUMMARY ANALYSIS

A structured settlement agreement is an arrangement for the periodic payment of damages for personal injuries in connection with a personal injury claim or lawsuit. Payees under such arrangements sometimes wish to forgo future payments in favor of an immediate cash payout. In short, current law requires certain disclosures and court approval before a payee may transfer his or her rights under a structured settlement.

The bill:

- Repeals the requirement to disclose the quotient;
- Requires the petition to the court for approval of the transfer to be filed in the county where the payee lives, or to the circuit where the underlying tort occurred if the payee is not a state resident;
- Allows a court to authorize assignment of the rights under a structured settlement notwithstanding a non-assignment clause;
- Requires the payee to attend the hearing;
- Requires additional information to be included in the petition for authority to transfer; and
- Makes other technical and style changes and other clarifications to the statute.

This bill does not appear to have a fiscal impact on state or local governments.

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

A structured settlement is an agreement for the periodic future payment of damages in a personal injury case.[1] This arrangement often involves the at-fault party in the personal injury claim or lawsuit paying a lump-sum premium to an insurance company to purchase an annuity in the name of and for the benefit of the injured party (the payee). Once the annuity is purchased, the insurance company begins to make periodic payments to the payee for the negotiated period of time. A structured settlement arrangement provides the payee long-term financial stability, and may provide tax benefits for beneficiaries[2] and annuity issuers.[3]

For some payee's, however, their personal financial circumstances may change, or they may simply want to "cash out" the future annuity. As such, instead of receiving payments under a structured settlement plan, the payee may wish to transfer his or her rights to future payments to another organization—known as a transferee—in exchange for a lump sum.[4]

In 2001, the Legislature created s. 626.99296, F.S., to regulate the transfer of structured settlements. Fundamentally, the statute requires such transfers to receive prior court approval.[5] This approval must be conditioned upon statutorily-enumerated factors, including an explicit finding by the court that the transfer is "in the best interests of the" individual opting to sell his or her settlement rights in order to receive a lump sum.[6] The entity contracting to receive the structured settlement rights must file an application with the court at least 20 days before the application hearing[7] and must make a series of disclosures to the payee.[8]

Disclosure of the Quotient

One of the required disclosures that must be made to a payee is the "quotient" of the transaction.[9] The "quotient" is described by statute as "a percentage, obtained by dividing the net payment amount by the discounted present value of the payments."[10] The bill repeals the requirement that the quotient be disclosed to the payee as a part of the pre-transfer disclosures.

Venue

The legal term "venue" refers to the place in which a case can be filed and pursued. In general, venue is proper where the cause of action accrued[11] or where the defendant resides. However, the plaintiff

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[1] *See* s. 626.99296(2)(m), F.S. Structured settlements occur in all forms of personal injury matters, including worker's compensation claims.
[2] 26 U.S.C. § 104 (providing that, for taxation purposes, gross income does not include the amount of damages received on account of personal physical injuries or physical sickness); s. 626.99296(2)(j), F.S. (defining "payee" as an individual receiving tax-free damage payments under a structured settlement).
[3] *See* 26 U.S.C. § 130; *First Providian, LLC v. Evans*, 852 So. 2d 908 (Fla. 4th DCA 2003).
[4] *See, e.g., First Providian, LLC v. Evans*, 852 So. 2d 908 (Fla. 4th DCA 2003).
[5] s. 626.99296(3)(a), F.S.; *Rapid Settlements, Ltd. v. Dickerson*, 941 So. 2d 1275, 1276-77 (Fla. 4th DCA 2006) (affirming lower court decision to deny petition, noting that "[t]ransfers of structured settlement rights are regulated by statute and court approval is required before a transfer may go forward.").
[6] s. 626.99296(3)(a)3., F.S.
[7] s. 626.99296(4), F.S.
[8] s. 626.99296(3), F.S.
[9] s. 626.99296(3)(a)2.g., F.S.
[10] *Id.*
[11] The structured settlements referenced in this bill arise from tort claims. The cause of action for a tort claim accrues in the jurisdiction where the injury occurs.

picks a venue by the act of filing the case, and if the defendant does not object then it is said that venue is waived and the case proceeds where it was filed. Thus, where the parties agree, and unless a statute provides otherwise, a case can be filed in any court that has jurisdiction.

The bill limits venue of a case regarding approval of the transfer of a structured settlement to the circuit court where the payee resides. If the payee is not domiciled in the state, then venue is proper in the circuit court that approved the structured settlement or the circuit court where the case was pending when the parties agreed to a structured settlement.

Non-Assignment Clauses

A structured settlement is a contract that is initially one between the original payor and the original payee. The parties to a contract are generally free to include any term they wish into the contract. At common law, a party to most contracts is free to assign his or her rights and obligations under the contract to another unless there is a statute or contract clause that limits or prohibits assignment. Many structured settlement contracts prohibit the payee from assigning (selling) the right to future payments.[12]

Like all contract terms, a non-assignment clause is not absolute. It is also a fundamental concept of contract law that the parties to a contract may agree to modify or change the terms of the contract. Thus, the parties to a structured settlement agreement may agree to waive a non-assignment clause.

The bill adds that, where the structured settlement prohibits transfer of the payment rights, a court nonetheless may conduct a hearing regarding transfer, the parties to the structured settlement may waive or assert their right under the clause, and the court may rule on the merits of the application for transfer.

Please see section entitled CONSTITUTIONAL ISSUES below regarding this provision of the bill.

Procedural Changes

Current law provides procedural requirements related to a court approval of the transfer of a structured settlement.[13] The bill:

- changes the time for filing of a written response to a petition for approval of transfer from "within 15 days after service of the petition" to at least 5 days prior to the hearing;[14]
- adds that the transferee is the person responsible for filing the petition;

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[12] One reason for such clauses was a provision in federal tax law, now repealed, that penalized the payor should the payee take a lump sum payout. Another significant reason for a non-assignment clause is that one goal of a structured settlement arrangement is the protection of a payee who may be naïve, financially unsophisticated, or who relies on the periodic payments as his or her sole means of support.

[13] s. 626.99296(4), F.S.

[14] *E.g.*, *First Providian, LLC v. Evans*, 852 So. 2d 908, 908 (Fla. 4th DCA 2003) (where the court dealt with a late filed response by a defendant insurance company). The change from "within 15 days after service of the transferee's notice" to "at least 5 days before the date of the scheduled hearing" could extend the period an interested party has to file a response, or it may leave it unchanged. A transferee must give notice at least 20 days before the hearing. If the transferee only gave the minimum 20 day notice, the time period would remain unchanged (e.g., 20 day notice - 5 days before hearing = 15 day period to respond). If the transferee gave more than 20 days notice, the interested party would have more than a 15 day window. The window would increase by the difference between the length of the notice given and the 20 day minimum (e.g., 30 day notice - 5 days before hearing = 25 day period to respond). In sum, the change could increase the interested party's period to respond to the notice, and could never make it shorter than it already is.

- requires the payee to appear in person at the hearing, absent good cause; and
- requires the petition to include certain information regarding the payee and the transaction.

The information regarding the payee and the transaction is:

- the payee's age, domicile, and ages of the payee's dependents;
- a copy of the transfer agreement and disclosure statement;
- the reasons why the payee seeks to transfer the right to future payment under the structured settlement; and
- a summary statement of:
    - completed financial transactions between the payee and the transferee (or related entities) during the past 4 years;
    - denied transfers in the past 2 years;
    - all other transfers in the past 3 years; and
    - proposed transfers.

Other Changes Made by the Bill

The transfer of a structured settlement is, at its core, simply a form of a contract. The parties to a contract can specify the law that will apply in interpreting the contract, which will prevail in the absence of a controlling statute. Current law defines "applicable law" to limit the use of applicable law to only be those of the United States, Florida, the payee, any interested party, a court that approved a structured settlement, or a court in which the underlying tort claim was pending at settlement. The bill repeals the reference to laws of "any other interested party."

Included within the statute on transfer of structured settlements are disclosure requirements that apply to the creation of a structured settlement agreement.[15] The bill repeals from that paragraph the requirement to disclose that transfer of the structured settlement rights may have "serious adverse tax consequences."[16]

Current law provides that the provisions of s. 626.99296, F.S., cannot be waived by any person; the bill provides that this protection and limitation only applies to a payee.

The bill specifies that compliance with the contract, notice and court approval requirements is solely the responsibility of the transferee. The other parties to the transaction do not incur liability for noncompliance.

The bill specifies that a structured settlement obligor and an annuity issuer may rely on the court order approving transfer, and are only legally liable for paying according to the court order.

The bill requires that a waiver of the right to receive independent professional advice must be in writing.

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[15] s. 626.99296(3)(d), F.S.

[16] While a transfer of a structured settlement right may have significant federal income tax consequences, there are many instances where the transfer would have little impact. In general, personal injury proceeds for medical bills, property loss and pain and suffering damages are not considered income and thus the payee pays no income tax upon receipt. Personal injury proceeds that reimburse the claimant for lost wages, however, are taxable. Since a structured settlement is an agreement, the parties can usually designate the type of payout and thus avoid characterization as taxable income. However, where the facts require designation as income, the payments are taxable in the year received. Where a structured settlement for future lost wages is transferred in exchange for a lump sum, the payee may face a significant tax bill compounded by several factors, such as moving into a higher tax bracket and a large tax bill that may be forgotten until April 15 of the following year.

The bill repeals the requirement that the court find that the transferee has given notice to the payor of the transferee's name, address and taxpayer identification number.

The bill also makes technical, grammatical and style changes to the statute.

B. SECTION DIRECTORY:

Section 1 amends s. 626.99296, F.S., regarding transfers of structured settlement payments.

Section 2 provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill does not appear to have any impact on state revenues.

2. Expenditures:

   The bill does not appear to have any impact on state expenditures.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The bill does not appear to have any impact on local government revenues.

2. Expenditures:

   The bill does not appear to have any impact on local government expenditures.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have an indeterminate fiscal impact on persons owning a structured settlement and on the companies that purchase to rights to those future payments.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   One paragraph in the bill allows a court to hear and rule on the merits of an application to transfer a structured settlement even where the structured settlement contains a clause prohibiting its transfer and a party objects to the transfer. This paragraph may implicate art. I, s. 10 of the Florida Constitution and art. I, s. 10 of the United States Constitution, which limit the legislature from passing any law that impairs "the obligation of contracts."

As a threshold matter, a law must "substantially impair" a contractual right for it be constitutionally problematic.[17] The Florida Supreme Court has held that "[a]n impairment may be constitutional if it is reasonable and necessary to serve an important public purpose."[18]

Where a party objects to a law believing that the law impairs the obligation of a contract, the courts have adopted a balancing test to "determine whether the nature and extent of the impairment is constitutionally tolerable in light of the importance of the state's objective, or whether it unreasonably intrudes into the parties' bargain to a degree greater than is necessary to achieve that objective."[19] Factors considered in the balancing test include:

- Was the law enacted to deal with a broad, generalized economic or social problem?[20]
- Does the law operate in an area which was already subject to state regulation at the time the parties' contractual obligations were originally undertaken, or does it invade an area never before subject to regulation by the state?
- Does the law effect a temporary alteration of the contractual relationships of those within its coverage, or does it work a severe, permanent, and immediate change in those relationships irrevocably and retroactively?[21]

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 13, 2016, the Civil Justice Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment:

- changes the effective date to upon becoming law;
- repeals a requirement in current law regarding notice of the transferee's name, address and taxpayer identification number; and
- makes technical and style changes conforming the bill to the Senate.

This analysis is drafted to the committee substitute as passed by the Civil Justice Subcommittee.

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[17] *Pomponio v. Claridge of Pompano Condo., Inc.*, 378 So. 2d 774, 779 (Fla.1979) (citing *Allied Structural Steel Co. v. Spannaus*, 438 U.S. 234, 244-45 (1978)).
[18] *Id.* at 778–79 (*citing United States Trust Co.*, 431 U.S. at 25 (1977)).
[19] *Id.* at 780.
[20] In determining the purpose of a statute, courts frequently look to the legislature's express statements of intent in the statute. *See Pomponio*, 378 So. 2d at 781 (noting in its analysis of the public purpose of the statute that the specific objectives for the statute are "neither expressly articulated nor plainly evident" in the statute).
[21] *Id.* at 779.

1 A bill to be entitled
2 An act relating to transfers of structured settlement
3 payment rights; amending s. 626.99296, F.S.; revising
4 definitions; revising specified disclosures and
5 notices that are or may be required to be given in
6 order to effect transfers of structured settlement
7 payment rights and payments under such rights;
8 revising the time limit by which a written response to
9 an application for transferring such rights must be
10 filed; providing requirements for the filing and
11 contents of the application; requiring the court to
12 hold a hearing on the application; requiring a payee
13 to appear in person unless the court determines that
14 good cause exists to excuse the payee; providing that
15 the transferee is solely responsible for compliance
16 with certain requirements; providing that following
17 issuance of a court order approving the transfer, the
18 structured settlement obligor and annuity issuer may
19 rely on the order in redirecting certain payments and
20 are released and discharged from certain liability;
21 providing for construction if the terms of the
22 structured settlement prohibit transfer for payment
23 rights; conforming provisions to changes made by the
24 act; providing an effective date.
25
26 Be It Enacted by the Legislature of the State of Florida:

27
28 Section 1. Subsection (2) of section 626.99296, Florida
29 Statutes, is reordered and amended, and paragraphs (a) and (d)
30 of subsection (3), subsections (4) and (5), and paragraphs (a)
31 and (b) of subsection (6) of that section are amended, to read:
32 626.99296 Transfers of structured settlement payment
33 rights.—
34 (2) DEFINITIONS.—As used in this section, the term:
35 (a) "Annuity issuer" means an insurer that has issued an
36 annuity contract to be used to fund periodic payments under a
37 structured settlement.
38 (b) ~~(c)~~ "Applicable federal rate" means the most recently
39 published applicable rate for determining the present value of
40 an annuity, as issued by the United States Internal Revenue
41 Service pursuant to s. 7520 of the United States Internal
42 Revenue Code, as amended.
43 (c) ~~(b)~~ "Applicable law" means any of the following, as
44 applicable in interpreting the terms of a structured settlement:
45 1. The laws of the United States;
46 2. The laws of this state, including principles of equity
47 applied in the courts of this state; and
48 3. The laws of any other jurisdiction:
49 a. That is the domicile of the payee ~~or any other~~
50 ~~interested party~~;
51 b. Under whose laws a structured settlement agreement was
52 approved by a court; or

53 c. In whose courts a settled claim was pending when the
54 parties entered into a structured settlement agreement.
55 (d) "Assignee" means any party that acquires structured
56 settlement payment rights directly or indirectly from a
57 transferee of such rights.
58 (e) "Dependents" means a payee's spouse and minor children
59 and all other family members and other persons for whom the
60 payee is legally obligated to provide support, including spousal
61 maintenance.
62 (f) "Discount and finance charge" means the sum of all
63 charges that are payable directly or indirectly from assigned
64 structured settlement payments and imposed directly or
65 indirectly by the transferee and that are incident to a transfer
66 of structured settlement payment rights, including:
67 1. Interest charges, discounts, or other compensation for
68 the time value of money;
69 2. All application, origination, processing, underwriting,
70 closing, filing, and notary fees and all similar charges,
71 however denominated; and
72 3. All charges for commissions or brokerage, regardless of
73 the identity of the party to whom such charges are paid or
74 payable.
75
76 The term does not include any fee or other obligation incurred
77 by a payee in obtaining independent professional advice
78 concerning a transfer of structured settlement payment rights.

79 (g) "Discounted present value" means, with respect to a
80 proposed transfer of structured settlement payment rights, the
81 fair present value of future payments, as determined by
82 discounting the payments to the present using the most recently
83 published applicable federal rate as the discount rate.
84 (h) "Independent professional advice" means advice of an
85 attorney, certified public accountant, actuary, or other
86 licensed professional adviser:
87 1. Who is engaged by a payee to render advice concerning
88 the legal, tax, and financial implications of a transfer of
89 structured settlement payment rights;
90 2. Who is not in any manner affiliated with or compensated
91 by the transferee of the transfer; and
92 3. Whose compensation for providing the advice is not
93 affected by whether a transfer occurs or does not occur.
94 (i) "Interested parties" means:
95 1. The payee;
96 2. Any beneficiary irrevocably designated under the
97 annuity contract to receive payments following the payee's death
98 or, if such designated beneficiary is a minor, the designated
99 beneficiary's parent or guardian;
100 3. The annuity issuer;
101 4. The structured settlement obligor; or
102 5. Any other party <u>to the structured settlement</u> who has
103 continuing rights or obligations <u>to receive or make payments</u>
104 under the structured settlement.

105 (j) "Payee" means an individual who is receiving tax-free
106 damage payments under a structured settlement and proposes to
107 make a transfer of payment rights under the structured
108 settlement.
109 (k) "Qualified assignment agreement" means an agreement
110 providing for a qualified assignment, as authorized by 26 U.S.C.
111 s. 130 of the United States Internal Revenue Code, as amended.
112 (l) "Settled claim" means the original tort claim resolved
113 by a structured settlement.
114 (m) "Structured settlement" means an arrangement for
115 periodic payment of damages for personal injuries established by
116 settlement or judgment in resolution of a tort claim.
117 (n) "Structured settlement agreement" means the agreement,
118 judgment, stipulation, or release embodying the terms of a
119 structured settlement, including the rights of the payee to
120 receive periodic payments.
121 (o) "Structured settlement obligor" means the party who is
122 obligated to make continuing periodic payments to the payee
123 under a structured settlement agreement or a qualified
124 assignment agreement.
125 (p) "Structured settlement payment rights" means rights to
126 receive periodic payments, including lump-sum payments under a
127 structured settlement, whether from the structured settlement
128 obligor or the annuity issuer, if:
129 1. The payee ~~or any other interested party~~ is domiciled in
130 this state;

131 2. The structured settlement agreement was approved by a
132 court of this state; or
133 3. The settled claim was pending before the courts of this
134 state when the parties entered into the structured settlement
135 agreement.
136 (q) "Terms of the structured settlement" means the terms
137 of the structured settlement agreement; the annuity contract; a
138 qualified assignment agreement; or an order or approval of a
139 court or other government authority authorizing or approving the
140 structured settlement.
141 (r) "Transfer" means a sale, assignment, pledge,
142 hypothecation, or other form of alienation or encumbrance made
143 by a payee for consideration.
144 (s) "Transfer agreement" means the agreement providing for
145 transfer of structured settlement payment rights from a payee to
146 a transferee.
147 (t) "Transferee" means a person who is receiving or who
148 will receive structured settlement payment rights resulting from
149 a transfer.
150 (3) CONDITIONS TO TRANSFERS OF STRUCTURED SETTLEMENT
151 PAYMENT RIGHTS AND STRUCTURED SETTLEMENT AGREEMENTS.—
152 (a) A direct or indirect transfer of structured settlement
153 payment rights is not effective and a structured settlement
154 obligor or annuity issuer is not required to make a payment
155 directly or indirectly to a transferee <u>or assignee</u> of structured
156 settlement payment rights unless the transfer is authorized in

157 advance in a final order by a court of competent jurisdiction
158 which is based on the written express findings by the court
159 that:
160 1. The transfer complies with this section and does not
161 contravene other applicable law;
162 2. At least 10 days before the date on which the payee
163 first incurred an obligation with respect to the transfer, the
164 transferee provided to the payee a disclosure statement in bold
165 type, no smaller than 14 points in size, which specifies:
166 a. The amounts and due dates of the structured settlement
167 payments to be transferred;
168 b. The aggregate amount of the payments;
169 c. The discounted present value of the payments, together
170 with the discount rate used in determining the discounted
171 present value;
172 d. The gross amount payable to the payee in exchange for
173 the payments;
174 e. An itemized listing of all brokers' commissions,
175 service charges, application fees, processing fees, closing
176 costs, filing fees, referral fees, administrative fees, legal
177 fees, and notary fees and other commissions, fees, costs,
178 expenses, and charges payable by the payee or deductible from
179 the gross amount otherwise payable to the payee;
180 f. The net amount payable to the payee after deducting all
181 commissions, fees, costs, expenses, and charges described in
182 sub-subparagraph e.;

183 g. ~~The quotient, expressed as a percentage, obtained by~~
184 ~~dividing the net payment amount by the discounted present value~~
185 ~~of the payments, which must be disclosed in the following~~
186 ~~statement: "The net amount that you will receive from us in~~
187 ~~exchange for your future structured settlement payments~~
188 ~~represent .... percent of the estimated current value of the~~
189 ~~payments based upon the discounted value using the applicable~~
190 ~~federal rate";~~
191 ~~h.~~ The effective annual interest rate, which must be
192 disclosed in the following statement: "Based on the net amount
193 that you will receive from us and the amounts and timing of the
194 structured settlement payments that you are turning over to us,
195 you will, in effect, be paying interest to us at a rate of ....
196 percent per year"; and
197 h.~~i.~~ The amount of any penalty and the aggregate amount of
198 any liquidated damages, including penalties, payable by the
199 payee in the event of a breach of the transfer agreement by the
200 payee;
201 3. The payee has established that the transfer is in the
202 best interests of the payee, taking into account the welfare and
203 support of the payee's dependents;
204 4. The payee has received, or waived in writing his or her
205 right to receive, independent professional advice regarding the
206 legal, tax, and financial implications of the transfer;
207 ~~5. The transferee has given written notice of the~~
208 ~~transferee's name, address, and taxpayer identification number~~

209 ~~to the annuity issuer and the structured settlement obligor and~~
210 ~~has filed a copy of the notice with the court;~~
211 5.~~6.~~ The transfer agreement provides that if the payee is
212 domiciled in this state, any disputes between the parties will
213 be governed in accordance with the laws of this state and that
214 the domicile state of the payee is the proper venue to bring any
215 cause of action arising out of a breach of the agreement; and
216 6.~~7.~~ The court has determined that the net amount payable
217 to the payee is fair, just, and reasonable under the
218 circumstances then existing.
219 (d) In negotiating a structured settlement of claims
220 brought by or on behalf of a claimant who is domiciled in this
221 state, the structured settlement obligor must disclose in
222 writing to the claimant or the claimant's legal representative
223 all of the following information that is not otherwise specified
224 in the structured settlement agreement:
225 1. The amounts and due dates of the periodic payments to
226 be made under the structured settlement agreement. In the case
227 of payments that will be subject to periodic percentage
228 increases, the amounts of future payments may be disclosed by
229 identifying the base payment amount, the amount and timing of
230 scheduled increases, and the manner in which increases will be
231 compounded;
232 2. The amount of the premium payable to the annuity
233 issuer;
234 3. The discounted present value of all periodic payments

235 that are not life-contingent, together with the discount rate
236 used in determining the discounted present value;
237 4. The nature and amount of any costs that may be deducted
238 from any of the periodic payments; and
239 5. Where applicable, that any transfer of the periodic
240 payments is prohibited by the terms of the structured settlement
241 and may otherwise be prohibited or restricted under applicable
242 law~~; and~~
243 ~~6. That any transfer of the periodic payments by the~~
244 ~~claimant may subject the claimant to serious adverse tax~~
245 ~~consequences~~.
246 (4) VENUE ~~JURISDICTION~~; PROCEDURE FOR APPROVAL OF
247 TRANSFERS; CONTENTS OF APPLICATION.—
248 (a) At least 20 days before the scheduled hearing on an
249 application for authorizing a transfer of structured settlement
250 payment rights under this section, the transferee must file with
251 the court and provide to all interested parties a notice of the
252 proposed transfer and the application for its authorization. The
253 notice must include:
254 1.~~(a)~~ A copy of the transferee's application to the court;
255 2.~~(b)~~ A copy of the transfer agreement;
256 3.~~(c)~~ A copy of the disclosure statement required under
257 subsection (3);
258 4.~~(d)~~ Notification that an interested party may support,
259 oppose, or otherwise respond to the transferee's application, in
260 person or by counsel, by submitting written comments to the

261 court or by participating in the hearing; and
262 5.~~(c)~~ Notification of the time and place of the hearing
263 and notification of the manner in which and the time by which
264 any written response to the application must be filed in order
265 to be considered by the court. A written response to an
266 application must be filed at least 5 ~~within 15~~ days before the
267 date ~~after service~~ of the scheduled hearing in order to be
268 considered by the court ~~transferee's notice~~.
269 (b) An application must be made by the transferee and
270 filed in the circuit court of the county in which the payee is
271 domiciled. However, if the payee is not domiciled in this state,
272 the application may be filed in the court in this state which
273 approved the structured settlement agreement or in the court in
274 which the settled claim was pending when the parties entered
275 into the structured settlement.
276 (c) The court shall hold a hearing on the application. The
277 payee shall appear in person at the hearing unless the court
278 determines that good cause exists to excuse the payee from
279 appearing.
280 (d) In addition to complying with the other requirements
281 of this section, the application must include:
282 1. The payee's name, age, and county of domicile and the
283 number and ages of the payee's dependents;
284 2. A copy of the transfer agreement;
285 3. A copy of the disclosure statement required under
286 subsection (3);

287 4. An explanation of reasons as to why the payee is
288 seeking approval of the proposed transfer; and
289 5. A summary of each of the following:
290 a. Any transfers by the payee to the transferee or an
291 affiliate, or through the transferee or an affiliate to an
292 assignee, within the 4 years before the date of the transfer
293 agreement.
294 b. Any transfers within the 3 years before the date of the
295 transfer agreement made by the payee to any person or entity
296 other than the transferee or an affiliate, or an assignee of a
297 transferee or an affiliate, to the extent such transfers were
298 disclosed to the transferee by the payee in writing or are
299 otherwise actually known by the transferee.
300 c. Any proposed transfers by the payee to the transferee
301 or an affiliate, or through the transferee or an affiliate to an
302 assignee, for which an application was denied within the 2 years
303 before the date of the transfer agreement.
304 d. Any proposed transfers by the payee to any person or
305 entity other than the transferee, or an assignee of a transferee
306 or an affiliate, to the extent such proposed transfers were
307 disclosed to the transferee by the payee in writing or are
308 otherwise actually known by the transferee, for which
309 applications were denied within the year before the date of the
310 transfer agreement.
311 (5) WAIVER PROHIBITED; NO PENALTIES INCURRED BY PAYEE;
312 RELIANCE ON COURT ORDER; COMPLIANCE; RELEASE FROM LIABILITY;

313 CONSTRUCTION.—
314 (a) The provisions of this section may not be waived by
315 the payee.
316 (b) If a transfer of structured settlement payment rights
317 fails to satisfy the conditions of subsection (3), the payee who
318 proposed the transfer does not incur any penalty, forfeit any
319 application fee or other payment, or otherwise incur any
320 liability to the proposed transferee.
321 (c) In a transfer of structured settlement payment rights,
322 the transferee is solely responsible for compliance with the
323 requirements of paragraph (3)(a) and subsection (4), and neither
324 the structured settlement obligor nor the annuity issuer shall
325 incur any liability arising from noncompliance.
326 (d) After issuance of a court order approving a transfer
327 of structured settlement payment rights under this section, the
328 structured settlement obligor and annuity issuer:
329 1. May rely on the court order in redirecting future
330 structured settlement payments to the transferee or an assignee
331 in accordance with the order; and
332 2. Are released and discharged from any liability for the
333 transferred payments to any party except the transferee or an
334 assignee, notwithstanding the failure of any party to the
335 transfer to comply with this section or with the orders of the
336 court approving the transfer.
337 (e) If the terms of the structured settlement prohibit
338 transfer of payment rights:

339 1. A court is not precluded from hearing an application
340 for approval of a transfer of such payment rights or ruling on
341 the merits of the application and any objections to the
342 application; and
343 2. The parties to such structured settlement are not
344 precluded from waiving or asserting their rights under such
345 terms.
346 (6) NONCOMPLIANCE.—
347 (a) If a transferee violates the requirements for
348 stipulating the discount and finance charge provided for in
349 subsection (3), neither the transferee nor any assignee may
350 collect from the transferred payments, or from the payee, any
351 amount in excess of the net advance amount, and the payee may
352 recover from the transferee or any assignee:
353 1. A refund of any excess amounts previously received by
354 the transferee or any assignee;
355 2. A penalty in an amount determined by the court, but not
356 in excess of three times the aggregate amount of the discount
357 and finance charge; and
358 3. Reasonable costs and attorney ~~attorney's~~ fees.
359 (b) If the transferee violates the disclosure requirements
360 in subsection (3), the transferee and any assignee are liable to
361 the payee for:
362 1. A penalty in an amount determined by the court, but not
363 in excess of three times the amount of the discount and finance
364 charge; and

365 2. Reasonable costs and attorney ~~attorney's~~ fees.
366 Section 2. This act shall take effect upon becoming a law.

Insurance & Banking Subcommittee

CS/HB 379 by Rep. Santiago
Transfers of Structured Settlement Payment Rights

AMENDMENT SUMMARY
February 1, 2016

Amendment 1 by Rep. Santiago (Line 345): The amendment conforms the bill to its Senate companion. It provides that provisions created by the bill shall not be construed to authorize transfers in contravention of law.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Santiago offered the following:
4
5 **Amendment (with title amendment)**
6 Between lines 345 and 346, insert:
7 (f) Nothing contained in this section shall be construed to
8 authorize any transfer of structured settlement payment rights
9 in contravention of applicable law.
10
11
12 ----------
13 **T I T L E A M E N D M E N T**
14 Remove line 23 and insert:
15 rights; resolving possible conflict of laws; conforming
16 provisions to changes made by the

HB 543

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 543 Small Group Health Insurance
SPONSOR(S): Stark and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 910

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	13 Y, 0 N	Tuszynski	Poche
2) Insurance & Banking Subcommittee		Peterson	Luczynski
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.

The Florida Employee Health Care Access Act (EHCAA) was enacted in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status. The EHCAA requires health insurers and health maintenance organizations (small employer carriers) in the small group market to offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer.

A small employer carrier that offers coverage to a small employer must offer coverage to all of the employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees. A small employer is neither required by state or federal law to provide insurance to its employees, nor, if coverage is provided to employees, to make it available to their dependents.

Under PPACA, if the cost of an employee-sponsored plan would cover an employee for 9.66 percent or less of household income, the employee and his or her dependents are not eligible for premium tax credits to purchase a health insurance plan on the Health Insurance Marketplace (Marketplace), nor are they eligible for cost-sharing reductions to lower their out-of-pocket payments for health services. This may make the cost of coverage unaffordable.

HB 543 amends s. 627.6699(5)(e)5., F.S., to provide a small employer with the option to offer employee-only coverage to all eligible employees. The bill clarifies that a small employer may offer coverage to the spouse and dependents of an eligible employee, but is not required to offer such coverage.

By clarifying that a small employer is not required to offer dependent coverage, dependents would not have an offer of affordable employer-based coverage that otherwise would disqualify them from receiving premium tax credits or other cost-sharing reductions to offset the cost of an insurance plan through the Marketplace. Such coverage through the Marketplace may be cheaper than the cost of the family coverage through employer-sponsored insurance.

This bill does not appear to have a fiscal impact on state or local government.

The bill provides for an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Patient Protection and Affordable Care Act

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[1] PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.[2]

Many of the changes outlined in PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[3] For example, PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):[4]

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

PPACA prohibits an insurer from establishing rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or any other health-status related factor deemed appropriate by the U.S. Department of Health and Human Services.[5]

PPACA – Limited Preemption of State Law

Under the U.S. Constitution's Supremacy Clause, a federal law may preempt state law.[6] Preemption occurs when Congress intentionally enacts legislation that is intended to supersede state law on the same subject.[7] In PPACA, Congress expressed that the federal law preempts state law only to the extent that it prevents the application of a provision of PPACA.[8]

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[1] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148. On March 30, 2010, PPACA was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.
[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] 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. *See* PPACA § 1251; 42 U.S.C. § 18011.
[4] PPACA § 1302; 42 U.S.C. § 300gg-6.
[5] PPACA § 1201; 42 U.S.C. § 300gg-4.
[6] U.S. Const. art. VI, cl. 2.
[7] *West Florida Regional Medical Center v. See*, 79 So.3d 1, 15 (Fla. 2012).
[8] PPACA § 1321(d); 42 U.S.C. § 18041(d).

Title I of PPACA, which includes the requirements related to health insurance regulation, contains the following provision:

No Interference With State Regulatory Authority – Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.[9]

Though expressed in the negative, PPACA preempts any state law that prevents the application of a provision of PPACA. PPACA effectively allows states to adopt and enforce laws that do not directly conflict with PPACA, but preempts any state law that does.[10]

Health Insurance Marketplaces

The Health Insurance Marketplace (Marketplace) is an online shopping platform for people to purchase insurance if they do not have insurance through their employer, Medicare, Medicaid, the Children's Health Insurance Program, or another source that provides qualifying coverage.[11] An individual may purchase insurance through the Marketplace even if he or she has access to employer-sponsored insurance. However, an individual with access to employer-sponsored insurance will not be eligible for premium tax credits unless the employer's insurance option does not meet certain standards.[12]

Health Insurance Premium Tax Credits in the Marketplace

Under PPACA, individuals and families with incomes between 100 percent and 400 percent of the Federal Poverty Level ($11,770 - $46,080 for an individual and $24,250 - $ 97,000 for a family of 4)[13] who purchase coverage through the Marketplace are eligible for a tax credit to reduce the cost of coverage. The amount of the tax credit varies based on income such that the premium a person would have to pay for the second least expensive silver plan[14] on the Marketplace would not exceed a percentage of their income, as follows:[15]

Income Level	Premium as a Percent of Income
Up to 133 percent FPL	2.03 percent of income
133 – 150 percent FPL	3.05 – 4.07 percent of income
150 – 200 percent FPL	4.07 – 6.41 percent of income
200 – 250 percent FPL	6.41 – 8.18 percent of income
250 – 300 percent FPL	8.18 – 9.66 percent of income
300 – 400 percent FPL	9.66 percent of income

[9] *Id.*
[10] National Association of Insurance Commissioners, *"Preemption and State Flexibility in PPACA" available at* http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf (last visited Jan. 26, 2016).
[11] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *A quick guide to the Health Insurance Marketplace*, available at: https://www.healthcare.gov/quick-guide/ (last viewed January 23, 2016).
[12] *Id.*
[13] HEALTHCARE.GOV, *Federal Poverty Guidelines, available at* https://aspe.hhs.gov/2015-poverty-guidelines (last visited Jan. 26, 2016).
[14] PPACA designates required coverage levels as bronze, silver, gold, or platinum. Each of these tiers corresponds to an actuarial value of the qualified health plans within that tier. The actuarial value corresponds to the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70 percent, on average, an individual would be responsible for 30 percent of the costs of all covered benefits through co-pays and other cost-sharing mechanisms. The corresponding actuarial values to the PPACA tiers are: Bronze – 60 percent; Silver – 70 percent; Gold – 80 percent; and Platinum – 90 percent.
[15] INTERNAL REVENUE SERVICE, *Internal Revenue Bulletin: 2014-50*, Dec. 8, 2014, *available* at https://www.irs.gov/irb/2014-50_IRB/ar11.html (last visited Jan. 26, 2016).

Florida Employee Heath Care Access Act

The Employee Health Care Access Act (EHCAA)[16] was enacted in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status.[17] The EHCAA requires health insurers and health maintenance organizations (small employer carriers) in the small group market to offer and issue all small employer benefit plans on a guaranteed-issue basis to every eligible small employer.[18] The EHCAA defines a small employer in terms of businesses with 50 or fewer employees.[19]

A small employer carrier that offers coverage to a small employer must offer coverage to all of the small employer's eligible employees[20] and their dependents.[21,22] A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.[23] In the small group market, under most employer-sponsored group health plans, employers subsidize the employee's premium but dependent coverage is offered under the plan completely at the employee's expense.[24] As such, it is often unaffordable.

A small employer is neither required by state or federal law to provide insurance to its employees, nor, if coverage is provided to employees, to make it available to their dependents.[25] Thus, a small employer could decline the dependent coverage that a small employer carrier is required by the EHCAA to offer. The OIR has indicated, however, that it has received comment that there is confusion in the insurance market as to whether a small employer has the option to offer employee-only coverage.[26]

Employer-Sponsored Insurance Offered to Dependents

Eligibility for federal premium tax credits to purchase health insurance from the Marketplace is not solely determined by income. It is also subject to whether a family has access to affordable employer-sponsored insurance.[27] The problem is that the definition of "affordable" – for both an individual employee and a family – is based on the cost of individual-only coverage and does not take into consideration the often significantly higher cost of a family plan.[28]

Under PPACA, an individual and family members who can enroll in "affordable" employer-based health insurance are not eligible for federal tax subsidies to reduce the price of a Marketplace plan or for cost-sharing reductions to lower their out-of-pocket payments for health services. An employer-sponsored plan is deemed "affordable" if the coverage to the employee costs less than 9.66 percent of household income, even if the cost for family coverage is substantially higher.[29] For example, if an employee can purchase an employee-only plan and the cost is only 9.5 percent of his or her household income, but

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[16] s. 627.6699, F.S.
[17] Ch. 92-33, Laws of Fla.
[18] s. 627.6699(5)(b), F.S.
[19] *See generally* s. 627.6699(3)(v), F.S.
[20] Section 627.6699(3)(g), F.S., defines an "eligible employee" as an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.
[21] Section 627.6699(3)(f), F.S., defines a "dependent" as the spouse or child of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee.
[22] s. 627.6699(5)(e)5., F.S.
[23] *Id.*
[24] *Infra* note 36, at 2.
[25] Florida Office of Insurance Regulation, *Agency Analysis of 2016 House Bill* 543, p. 2 (Dec. 18, 2015). *See generally* HEALTHCARE.GOV, *How the Affordable Care Act affects small businesses,* https://www.healthcare.gov/small-businesses/health-care-law-and-business/how-aca-affects-businesses/ (last visited Jan. 26, 2016).
[26] *Id.* at 4.
[27] Health Affairs, *Health Policy Briefs, The Family Glitch*, at 1, *available at:* http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129 (last visited Jan. 26, 2016).
[28] *Id.*
[29] *Id.*

the family option costs 13 percent of household income and is unaffordable, the family members are still ineligible for premium tax credits. This is referred to as the "family glitch" in PPACA – the family is priced out of the Marketplace because they have been offered an affordable employee-sponsored plan and are not eligible for premium tax credits, yet the employer-based family option is out of the family's budget.

Florida Health Insurance Advisory Board

The Florida Health Insurance Advisory Board (Board) was established in 1992 as the Small Employer Health Reinsurance Program.[30] Its purpose was to promote the availability of health care coverage to small employers.[31] At that time, Board members were primarily representatives of health insurers licensed under ch. 624 or 641, F.S.[32] In 2005, the Legislature expanded the composition of the Board to include representatives of employers, an individual policyholder, and a representative from the Agency for Health Care Administration (AHCA).[33] The Board's responsibilities were expanded to include an advisory role on health insurance issues to the Office of Insurance Regulation (OIR), AHCA, the Department of Financial Services, other executive departments and the Legislature.[34]

In its legislative recommendations for 2014,[35] 2015,[36] and 2016[37] the Board has recommended that the statutes be amended to clarify that small group employers be specifically allowed the option to offer employee-only coverage, which would allow spouses and dependents to obtain coverage in the Marketplace, where they may qualify for a premium tax credit.

Effect of the Proposed Changes

HB 543 amends s. 627.6699(5)(e)5., F.S., to provide a small employer with the option to offer employee-only coverage to all eligible employees. The bill clarifies that a small employer may offer coverage to the spouse and dependents of an eligible employee, but is not required to offer such coverage.

This clarification allows employers to inform small group carriers that they have made the choice to offer employee-only coverage. This, in turn, allows the small group carrier to offer such coverage and not extend an offer of coverage to dependents of an eligible employee.

By clarifying that a small employer is not required to offer dependent coverage, dependents will not have an offer of affordable employer-based coverage that would otherwise disqualify them from obtaining premium tax credits to offset the cost of an insurance plan through the Marketplace. Insurance through the Marketplace, subsidized by the premium tax credits, may be cheaper than the cost of the family coverage through employer-sponsored insurance.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.
Section 2: Provides for an effective date of July 1, 2016.

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[30] FLORIDA OFFICE OF INSURANCE REGULATION, *Florida Health Insurance Advisory Board, available at* http://www.floir.com/sections/landh/fhiab.aspx (last visited Jan. 26, 2016).
[31] *Id.*
[32] *Id.*
[33] Ch. 2005-231, Laws of Fla.
[34] *Id.*
[35] FLORIDA OFFICE OF INSURANCE REGULATION, *Florida Health Insurance Advisory Board, 2014 Legislative Recommendations, available at* http://www.floir.com/siteDocuments/FHIABLegRecommendations2014.pdf (last visited Jan. 26, 2016).
[36] FLORIDA OFFICE OF INSURANCE REGULATION, *Florida Health Insurance Advisory Board, 2015 Legislative Recommendations, available at* http://www.floir.com/siteDocuments/FHIABLegRecommendations2015.pdf (last visited Jan. 26, 2016).
[37] FLORIDA OFFICE OF INSURANCE REGULATION, *Florida Health Insurance Advisory Board, 2016 Legislative Recommendations, available at* http://www.floir.com/siteDocuments/FHIABLegRecommendations2016.pdf (last visited Jan. 26, 2016).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

For low to moderate-income families that qualify for premium tax credits to purchase health insurance through the Marketplace, dependents of employees of a small employer may have access to less expensive coverage as compared to the cost of family coverage through the employer. The OIR has expressed concern, however, that the effect of the bill may be for small employers to drop dependent coverage, even under circumstances where a less expensive option may not be available in the Marketplace.[38]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[38] *Supra* note 25, at 4.

1 A bill to be entitled
2 An act relating to small group health insurance;
3 amending s. 627.6699, F.S.; revising health benefit
4 plan requirements relating to small employers;
5 providing an effective date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Paragraph (e) of subsection (5) of section
10 627.6699, Florida Statutes, is amended to read:
11 627.6699 Employee Health Care Access Act.—
12 (5) AVAILABILITY OF COVERAGE.—
13 (e) All health benefit plans issued under this section
14 must comply with the following conditions:
15 1. For employers who have fewer than two employees, a late
16 enrollee may be excluded from coverage for no longer than 24
17 months if he or she was not covered by creditable coverage
18 continually to a date not more than 63 days before the effective
19 date of his or her new coverage.
20 2. Any requirement used by a small employer carrier in
21 determining whether to provide coverage to a small employer
22 group, including requirements for minimum participation of
23 eligible employees and minimum employer contributions, must be
24 applied uniformly among all small employer groups having the
25 same number of eligible employees applying for coverage or
26 receiving coverage from the small employer carrier, except that

27 a small employer carrier that participates in, administers, or
28 issues health benefits pursuant to s. 381.0406 which do not
29 include a preexisting condition exclusion may require as a
30 condition of offering such benefits that the employer has had no
31 health insurance coverage for its employees for a period of at
32 least 6 months. A small employer carrier may vary application of
33 minimum participation requirements and minimum employer
34 contribution requirements only by the size of the small employer
35 group.
36 3. In applying minimum participation requirements with
37 respect to a small employer, a small employer carrier shall not
38 consider as an eligible employee employees or dependents who
39 have qualifying existing coverage in an employer-based group
40 insurance plan or an ERISA qualified self-insurance plan in
41 determining whether the applicable percentage of participation
42 is met. However, a small employer carrier may count eligible
43 employees and dependents who have coverage under another health
44 plan that is sponsored by that employer.
45 4. A small employer carrier shall not increase any
46 requirement for minimum employee participation or any
47 requirement for minimum employer contribution applicable to a
48 small employer at any time after the small employer has been
49 accepted for coverage, unless the employer size has changed, in
50 which case the small employer carrier may apply the requirements
51 that are applicable to the new group size.
52 5. If a small employer carrier offers coverage to a small

53 employer, it must offer coverage to all the small employer's
54 eligible employees and their dependents. A small employer
55 carrier may not offer coverage limited to certain persons in a
56 group or to part of a group, except with respect to late
57 enrollees. If a small employer offers coverage to its employees,
58 the coverage must be offered to all eligible employees. The
59 small employer may also offer coverage to the spouses and
60 dependents of eligible employees.
61 6. A small employer carrier may not modify any health
62 benefit plan issued to a small employer with respect to a small
63 employer or any eligible employee or dependent through riders,
64 endorsements, or otherwise to restrict or exclude coverage for
65 certain diseases or medical conditions otherwise covered by the
66 health benefit plan.
67 7. An initial enrollment period of at least 30 days must
68 be provided. An annual 30-day open enrollment period must be
69 offered to each small employer's eligible employees and their
70 dependents. A small employer carrier must provide special
71 enrollment periods as required by s. 627.65615.
72 Section 2. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 783 Unclaimed Property
SPONSOR(S): Trumbull
TIED BILLS: **IDEN./SIM. BILLS:** SB 970

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Lloyd	Luczynski
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

Unclaimed property consists of any funds or other property, including insurance proceeds, that remains unclaimed by the owner for a certain period of time. The Florida Disposition of Unclaimed Property Act requires holders of unclaimed property to exercise due diligence to locate owners and pay them the funds. If the owner cannot be located, the holder must report and remit the unclaimed property to the Department of Financial Services (DFS) Bureau of Unclaimed Property. The bill makes the following changes to the Act:

- Revises certain definitions and adds one for the term "United States";
- Increases the maximum value governing documentation standards for claims related to small estates from $5,000 to $10,000;
- Authorizes the DFS to estimate property value if the holder fails to produce sufficient records to do so and clarifies that the estimation requirement applies without regard to whether the holder is incorporated, formed, or organized in Florida;
- Eliminates the conditional $1,000 cap on fees and costs applicable to property claimed under a power of attorney and the conditional $1,000 limit on the discount allowed in purchase agreements;
- Eliminates an exception that removes a fee cap and disclosure requirement, in the case of a claim made under a power of attorney, or the $1,000 discount limit (but not the disclosure requirement) in the case of a claim for a property right obtained under a purchase agreement;
- Deletes authority to remove certain language otherwise required in purchase agreements;
- Establishes registration and renewal fees for representatives and purchasers of property claims and, by operation of law, suspends the transactional rights of registrants who fail to pay their renewal fee; and
- Removes the authorization for registrants to receive social security numbers.

If there are any undisbursed funds at the conclusion of a foreclosure, the clerk of the court assigns a DFS certified surplus trustee (paid by the clerk from the surplus funds) to attempt to locate the owner of record. The surplus trustees are assigned cases using a rotational system developed by the DFS. The bill prohibits the surplus trustee from having certain interests in more than one surplus trustee. The bill also authorizes the DFS to suspend the certification of surplus trustees that violate this provision.

Current law requires candidates for public office to dispose of the funds in their campaign account within 90 days of the end of their candidacy. They are allowed deposit refund checks to be disposed of consistent with law. However, the law does not specify how to dispose of funds that come in by other means after the disposition of the account. The bill provides that unclaimed campaign account property shall become the property of the state and the proceeds of the property shall be paid into the State School Fund.

The bill expressly states that a specified portion of the bill is intended to be remedial in nature and apply to unclaimed property existing before July 1, 2016.

The bill has no effect on local government or state expenditures. It has an indeterminate positive effect on state revenues. The bill has a mixed impact on the private sector.

The bill is effective July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Unclaimed Property

Unclaimed property constitutes any funds or other property, tangible or intangible, that has remained unclaimed by the owner for more than five years. Unclaimed property may include savings and checking accounts, money orders, travelers' checks, uncashed payroll or cashiers' checks, stocks, bonds, other securities, insurance policy payments, refunds, security and utility deposits, and contents of safe deposit boxes.[1]

In 1987, Florida adopted the Uniform Unclaimed Property Act[2] and enacted the Florida Disposition of Unclaimed Property Act (ch. 717, F.S., "the Act").[3] The Act serves to protect the interests of missing owners of property, while the state derives a benefit from the unclaimed and abandoned property until the property is claimed, if ever. Under the Act, the Department of Financial Services, Bureau of Unclaimed Property (DFS) is responsible for receiving property, attempting to locate the rightful owners, and returning the property or proceeds to them. There is no statute of limitations in the Act, and citizens may claim their property at any time and at no cost.

Generally, all intangible property, including any income less any lawful charges, which is held in the ordinary course of the holder's business, is presumed to be unclaimed when the owner fails to claim the property for more than five years after the property becomes payable or distributable, unless otherwise provided in the Act.[4] Holders of unclaimed property (which typically include banks and insurance companies) of $50 or more are required to use due diligence to locate and notify apparent owners of inactive accounts, at least 60 days but not more than 120 days prior to filing a report with the DFS.[5] If the owners cannot be located, holders must file an annual report with the DFS for all property, valued at $50 or more, that is presumed unclaimed for the preceding year.[6] The report must contain certain identifying information, such as the apparent owner's name, social security number or federal employer identification number, and last known address of apparent owners.[7] The holder must deliver all reportable unclaimed property to the DFS when it submits its annual report.[8]

Upon the payment or delivery of unclaimed property to the DFS, the state assumes custody and responsibility for the safekeeping of the property.[9] The original property owner retains the right to recover the proceeds of the property, and any person claiming an interest in the property delivered to the DFS may file a claim for the property, subject to certain requirements.[10] The DFS is required to make a determination on a claim within 90 days. If a claim is determined in favor of the claimant, the

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[1] ss. 717.104 – 717.116, F.S.

[2] UNIFORM LAW COMMISSION, *Unclaimed Property Act (1952)(1981)*, http://www.uniformlaws.org/Act.aspx?title=Unclaimed Property Act (1952)(1981) (last visited Jan. 29, 2016).

[3] Ch. 87-105, Laws of Fla. See also UNIFORM LAW COMMISSION, *Unclaimed Property Act Summary*, http://www.uniformlaws.org/ActSummary.aspx?title=Unclaimed%20Property%20Act (last visited Jan. 26, 2016).

[4] s. 717.102(1), F.S.

[5] s. 717.117(4), F.S.

[6] s. 717.117, F.S.

[7] For unclaimed funds owing under any life or endowment insurance policy or annuity contract, the report must also include the last known address of the insured or annuitant and of the beneficiary according to records of the insurance company holding or owing the funds. s. 717.117(1)(b), F.S.

[8] s. 717.119, F.S.

[9] s. 717.1201, F.S. Like many other states' unclaimed property acts, the Act is based on the common-law doctrine of escheat and is a "custody" statute, rather than a "title" statute, in that the DFS does not take title to abandoned property, but instead obtains its custody and beneficial use pending identification of the property owner.

[10] ss. 717.117 and 717.124, F.S.

DFS is to deliver or pay over to the claimant the property or the amount the DFS actually received or the proceeds, if it has been sold by the DFS.[11]

If the property remains unclaimed, all proceeds from abandoned property are then deposited by the DFS into the Unclaimed Property Trust Fund.[12] The DFS is allowed to retain up to $15 million to make prompt payment on verified claims and to cover costs incurred by the DFS in administering and enforcing the Act. All remaining funds received must be deposited into the State School Fund to be utilized for public education.[13]

Claims for recovery of unclaimed property held by the DFS under the Act may be filed by or on behalf of any person with an interest in the property.[14] While the Act provides the opportunity for anyone to recover the full value of their property at no cost, provision is made for claimants to designate someone who may perfect the claim for them. The claimant may designate and empower a representative to pursue their claim by executing a power of attorney agreement. Or, the claimant may sell their right to the property to certain individuals that are registered with the DFS for this purpose.[15] In either case, the transaction is subject to a fee limitation, unless a disclosure statement is provided to the claimant, in the form and with the content specified in the Act. The fee limitations are:

For representatives operating under a power of attorney:[16]

- 20 percent of the value of the property, not to exceed $1,000;
- However, the fee limitation does not apply if the representative must initiate probate proceedings for an estate that has never been probated before or if the claimant is outside of the United States.

For purchasers obtaining rights under a purchase agreement:[17]

- 20 percent discount off of the value of the property, not to exceed a discount of $1,000;
- However, the $1,000 discount limitation does not apply if the representative must initiate probate proceedings for an estate that has never been probated before, if the claimant is outside of the United States or is not a natural person, such as a business or similar entity.

The Act also prescribes the form and content of the purchase agreement that transfers the right of the claimant to another person and the document granting the power of attorney.

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[11] s. 717.124, F.S.
[12] s. 717.123, F.S.
[13] *Id.*
[14] s. 717.124, F.S.
[15] Only a Florida licensed attorney, certified public accountant, private investigator or an employee of private investigator, or an employer of the private investigator if the employer holds a Class "A" license under ch. 493, F.S., may execute such purchase agreements. s. 717.1351, F.S. Additionally, the purchaser must be registered with the DFS. The DFS reports that there are currently 246 registrants under this provision. Florida Department of Financial Services, Agency Analysis of 2016 HB 1327, p. 3 (Dec. 14, 2015).
[16] s. 717.135, F.S., requires the disclosure that the property is held by the DFS pursuant to the Act, the mailing and Internet addresses of the DFS, the person or name of the entity that held the property prior to the property becoming unclaimed, the date of the holder's last contact with the owner, if known, and the approximate value of the property, and the categories of unclaimed property the claimant's representative is seeking to recover. The categories of unclaimed property are: cash accounts; stale dated checks; life insurance or annuity contract assets; utility deposits; securities or other interests in business associations; wages; accounts receivable; and contents of safe-deposit boxes.
[17] s. 717.1351, F.S. The content of the disclosure statement has the same elements as the disclosure described in s. 717.135, F.S., related to powers of attorney. However, the fee limitation does not apply if the representative must initiate probate proceedings for an estate that has never been probated, if the claimant is outside of the United States or is not a natural person, such as a business or similar entity.

Since the public policy of the state is to provide the DFS with the first opportunity to locate the owner of the unclaimed property and for the owner to receive the full value of their property,[18] there are limitations on claiming by others through powers of attorney and purchase agreements. Powers of attorney and purchase agreements that are executed less than 45 days after the property is received by the DFS and that relate to accounts over $250 in value are void under the Act.[19] The 45 day limit on such claims provides the DFS the opportunity to attempt to locate the property's owner. However, placing time and value limits on claim eligibility requires the DFS to track accounts and audit claims to identify the amount and timing of the claims. The DFS reports that this is inefficient and the public purpose can be served through other provisions of the Act. The DFS recommends repealing s. 717.1381, F.S., to eliminate administrative inefficiency.[20] It is notable, though, that repealing s. 717.1381, F.S., would include the repeal of statements of legislative intent regarding the right of the claimant to recover their property without charge and the obligation of the DFS to make a meaningful attempt to locate the claimant.

Effect of the Bill

The bill revises the definitions of "business association," "domicile," and "insurance company" to simplify their text and improve understandability. Limited liability companies are specifically included in the definition of "business association." A definition of "United States" is created to specify the meaning of that term, which is currently used throughout the Act to determine various rights and conditions.

Generally, a claim for property related to the estate of a deceased person must be accompanied by an order from a probate court. However, there are documentary exceptions for estates with an aggregate value of $5,000 or less and no probate proceeding is pending.[21] The bill increases the maximum threshold value of this small estate provision from $5,000 to $10,000.

The bill eliminates the $1,000 cap on fees and costs applicable to property claimed through a representative under a power of attorney and the $1,000 limit on the discount allowed in purchase agreements. Since these caps limit the application of the primary fee limitation, which is 20 percent of the value of the property recovered under a power of attorney or a 20 percent discount on the purchase of the property right, the $1,000 limitation is only triggered when value of the property exceeds $5,000 (i.e., $5,000 x 0.20 = $1,000). Currently, there is no fee cap if the specified disclosure statement is provided to the claimant. The bill increases the cap on fees and costs to the current 20 percent standard on property valued over $5,000 where the specified disclosure is not made to the claimant.

The bill also eliminates the exception that removes the fee cap and disclosure requirement, in the case of a claim made under a power of attorney, or the $1,000 discount limit (but not the disclosure requirement) in the case of a claim for a property right obtained under a purchase agreement. The exception applies when probate proceedings must be initiated on behalf of the claimant regarding an estate that has never been probated or if the claim is being made under the right of a person outside the United States or, in the case of a purchase agreement, the seller is not a natural person.

Currently, purchase agreements are required to specify the percent of the property to be paid to the purchaser on a discrete line item of the purchase agreement pursuant to the form and content requirements of the Act. However, this line may be deleted if the purchaser is paid a flat fee instead of a percentage of the recovery. The bill eliminates this exception and requires every purchase agreement to include the required text regarding the percent of the property to be paid to the purchaser and the insertion of the appropriate percentage figure, which varies depending upon the amount of the flat fee and the value of the property to be recovered.

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[18] ss. 717.118 and 717.1381, F.S.
[19] s. 717.1381, F.S.
[20] Florida Department of Financial Services, Agency Analysis of 2016 HB 783, p. 3 (Dec. 14, 2015) and email from Elizabeth Boyd, Director of Legislative Affairs, Department of Financial Services, Re: 45 Day issue from HB 783 (Jan. 27, 2016).
[21] s. 717.1243, F.S.

Individuals who register with the DFS as a potential purchaser under the Act are permitted to receive the social security numbers of apparent property owners of property reported to the DFS. This is in addition to other information related to the unclaimed property. The bill deletes the authorization for registrants to receive social security numbers. Currently, there is no fee for registering with the DFS under the Act. The bill establishes a $500 registration fee and an annual $250 renewal fee. The registration fee is due upon application or reapplication following a lapse of registration. The renewal fee is due July 1st each year, with reapplication being required if the renewal fee is not paid by December 31st. Registrants who fail to pay their registration renewal fee lose their privileges until the fee is paid.

Surplus Trustees

Upon the conclusion of a foreclosure, any undisbursed funds are held in surplus by the clerk of the court for sixty days. If no legal claim is made for the surplus, the clerk is required to appoint a "surplus trustee" to locate the owner of the surplus. A surplus trustee is an entity that holds and administers surplus proceeds from a foreclosure pursuant to ss. 45.031–45.035, F.S. Surplus trustees are certified by the DFS. The clerks assign the surplus trustees to cases using a rotational system developed by the DFS.[22]

The primary duty of a surplus trustee is to locate the owner of record within 1 year after appointment. Upon locating the owner of record, the surplus trustee files a petition with the court on behalf of the owner of record seeking disbursement of the surplus funds. If more than one person appears to be the owner of record, the surplus trustee shall obtain agreement between such persons as to the payment of the surplus or file an interpleader. The interpleader may be filed as part of the foreclosure case. Surplus trustees are paid by the clerk from the foreclosure surplus.[23]

Various entities may qualify for certification by the DFS as a surplus trustee. Their application must include the following:

- The name and address of the entity and one or more principals of the entity;
- A certificate of good standing from the Secretary of State indicating that the entity is an entity registered in this state;
- A statement under oath by a principal of the entity certifying that the entity, or a principal of the entity, has a minimum of 12 months' experience in the recovery of surplus funds in foreclosure actions;
- Proof that the entity holds a valid Class "A" private investigator license pursuant to ch. 493, F.S.;
- Proof that the entity carries a minimum of $500,000 in liability insurance, cash reserves, or bonding;
- A statement from an attorney licensed to practice in this state certifying that the attorney is a principal of the entity or is employed by the entity on a full-time basis and that the attorney will supervise the management of the entity during the entity's tenure as a surplus trustee;
- A statement under oath by a principal of the entity certifying that the principal understands his or her duty to immediately notify the DFS if the principal ever fails to qualify as an entity entitled to be a surplus trustee; and
- A nonrefundable application fee of $25.

Effect of the Bill

The bill prohibits the surplus trustee from being an owner, shareholder, officer, member, employee, or participant in more than one surplus trustee company or corporation. The bill also requires the DFS to suspend the certification of the surplus trustee for one year, if the DFS finds that the surplus trustee has

[22] ss. 45.034 and 45.035, F.S.
[23] *Id.*

violated this limitation. Since surplus trustees are assigned by clerks using a rotation system developed by the DFS, the limitation on interests in multiple surplus trustees will prevent a disproportionate distribution of assignments that favors affiliated entities over independent entities.

Unclaimed Campaign Funds

Section 106.141, F.S., requires candidates for public office to dispose of the funds in their campaign account within 90 days of the date that their candidacy ended.[24] Paragraph 106.141(4)(a), F.S., specifies a variety of options for the disposal of surplus campaign funds. With certain exceptions, they may take any combination of the following actions when disposing of the surplus:

- Return, pro rata to each contributor, the funds that have not been spent or obligated;
- Donate the funds that have not been spent or obligated to a charitable organization or organizations that meet the qualifications of s. 501(c)(3) of the Internal Revenue Code;
- Give not more than $25,000 of the funds that have not been spent or obligated to the affiliated party committee or political party of which such candidate is a member; or
- Give the funds that have not been spent or obligated:
    - In the case of a candidate for state office, to the state, to be deposited in either the Election Campaign Financing Trust Fund or the General Revenue Fund, as designated by the candidate; or
    - In the case of a candidate for an office of a political subdivision, to such political subdivision, to be deposited in the general fund thereof.

If the candidate accepted contributions under the Florida Election Campaign Financing Act, the surplus funds must be returned to the General Revenue Fund, after satisfying certain monetary obligations. If the candidate takes office, they may transfer a limited amount of the funds to their office account.

Violations of the campaign finance law are subject to criminal penalties, both misdemeanors and felonies. Failure to properly dispose of surplus campaign funds is a first degree misdemeanor punishable by up to a year in jail and/or a fine of $1,000. Candidates are prohibited from accepting campaign contributions following the end of their candidacy. They are allowed to receive and deposit refund checks to be disposed of consistent with the requirements of law, as described above. However, the law does not specify how to dispose of cash (or other property), received in forms other than a check, that would otherwise go into the campaign account but comes into the possession of the former candidate after the end of their candidacy and the disposition of the campaign account.

Effect of the Bill

The bill provides that if unclaimed property is owned by the campaign account of a candidate for public office, following a report of the property to the DFS, the property shall become the property of the state and the proceeds of the property shall be paid into the State School Fund.

Retroactive and Remedial Application of Law

Newly enacted legislation is presumed to apply prospectively absent clear legislative intent to the contrary.[25] However, the intent for retrospective application of enacted legislation can be established through the express language of the statute or by analyzing the practical effect of the statute. If the intent for retrospective application is established, then it must be determined whether such application of the statute is constitutionally permissible.[26]

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[24] The triggers for disposition are when the candidate withdraws their candidacy, becomes an unopposed candidate, is eliminated, or is elected. s. 106.141(1), F.S.
[25] *See Metropolitan Dade County v. Chase Federal Housing Corp.*, 737 So.2d 494 (Fla. 1999).
[26] *Id.*

Effect of the Bill

The holder of unclaimed property is obligated to report the value of property to the DFS. If the holder's records are insufficient to permit preparation of the required report, the value of the property may be estimated. However, there is no authority for the DFS to estimate the value of the property when the holder fails to produce the record. The bill authorizes the estimation to occur if the holder fails to produce records following a request by the DFS. Additionally, it clarifies that the estimation requirement applies without regard to whether the holder is incorporated, formed, or organized in Florida.

The bill expressly states that this change is intended to be remedial in nature and apply to unclaimed property existing before July 1, 2016. This would apply the bill's provisions to unclaimed property regardless of the date that it first came within the provisions of the Act. Please see section entitled CONSTITUTIONAL ISSUES below regarding this provision of the bill.

B. SECTION DIRECTORY:

Section 1: Amends s. 45.034, F.S., relating to qualifications and appointment of a surplus trustee in foreclosure actions.

Section 2: Amends s. 717.101, F.S., relating to definitions applicable to the Florida Disposition of Unclaimed Property Act.

Section 3: Creates s. 717.1235, F.S., relating to unclaimed campaign funds of candidates for public office.

Section 4: Amends s. 717.1243, F.S., relating to small estate accounts.

Section 5: Amends s. 717.1333, F.S., relating to evidence; estimations; audit reports, examiner's worksheets, investigative reports, other related documents.

Section 6: Amends s. 717.135, F.S., relating to power of attorney to recover reported property in the custody of the department.

Section 7: Creates s. 717.1351, F.S., relating to acquisition of unclaimed property.

Section 8: Repeals s. 717.1381, F.S., relating to void unclaimed property powers of attorney and purchase agreements.

Section 9: Amends s. 717.1400, F.S., relating to registration.

Section 10: Provides legislative intent that changes made by Section 5 of the bill are remedial in nature and apply retroactively.

Section 11: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill has an indeterminate positive effect on state revenues. The bill creates certain fees that would be deposited to the Unclaimed Property Trust Fund and provides for certain property to become state property for deposit into the State School Fund.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill has a negative impact on the private sector because it creates new registration and renewal fees and, under certain circumstances, eliminates a current limit on fees that third parties may collect for assisting in the recovery of unclaimed property. The bill has a positive effect on the private sector by allowing more small estates to benefit from simpler claim filing requirements, increasing the informational content on certain disclosures and allowing the streamlining of claim processing by the DFS.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

The bill expressly states that the law change to s. 717.1333, F.S., is intended to be remedial in nature and apply to unclaimed property existing before July 1, 2016. This would apply the bill's provisions to unclaimed property regardless of the date that it first came within the provisions of the Act.

Newly enacted legislation is presumed to apply prospectively absent clear legislative intent to the contrary.[27] However, the intent for retrospective application of enacted legislation can be established through the express language of the statute or by analyzing the practical effect of the statute. If the intent for retrospective application is established, then it must be determined whether such application of the statute is constitutionally permissible.[28] Retroactive application is unconstitutional, and thereby prohibited, if:[29]

[27] *See Metropolitan Dade County v. Chase Federal Housing Corp.*, 737 So.2d 494 (Fla. 1999).
[28] *Id.*
[29] *Id.*

- Vested rights are adversely affected or destroyed;[30]
- A new obligation or duty is created or imposed; or
- An additional disability is established.

The Florida Supreme Court previously ruled that retroactive application of a remedial statute is constitutionally permissible and should occur to achieve the intended purpose of the statute.[31] Remedial statutes operate to further a remedy or confirm existing rights and do not create new obligations or adversely affect vested rights.[32] Further, when an amendment to a statute is enacted soon after controversies as to the interpretation of the original statute arise, a court may consider that amendment as legislative interpretation of the original law and not a substantive change of the law.[33]

The bill authorizes an estimation of property value if the holder fails to produce records following a request by the DFS. Additionally, it clarifies that the estimation requirement applies without regard to whether the holder is incorporated, formed, or organized in Florida. This creates a right of the DFS to provide an estimation. It does not limit the holder's opportunity to provide information or make an estimation prior to the DFS being prompted to make an estimate of its own. This does not appear to trigger any of the three considerations identified by the courts. The holder's rights are unaltered; none are affected, destroyed, created, or imposed. Nor is the holder's ability or capacity to exercise their right altered.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Among other specified limitations, the bill prohibits a surplus trustee from being an officer, member, or employee of more than one surplus trustee. These three descriptors relate to natural persons. Pursuant to s. 45.034, F.S., only entities can be a surplus trustee. This portion of the bill also provides for the suspension of violators by the DFS. This grant of disciplinary power may be incomplete or improperly located within statute.

The bill deletes authority currently in s. 717.1351(7), F.S., which authorizes the removal of certain language required in purchase agreements, if the agreement is based on a flat fee paid by the seller, rather than a percentage value of the property. However, the related provision in s. 717.135(4), F.S., that authorizes the deletion of substantively identical language in grants of limited power attorney is not deleted. The deletion of one provision and not the other may be inconsistent with the intent of the bill to require the disclosure of the percentage value of the property that will be paid to a third party for their service in locating and recovering property.

The bill repeals s. 717.1381, F.S., which contains certain legislative intent language regarding the right of the claimant to recover their property without charge and the obligation of the DFS to make a meaningful attempt to locate the claimant. Deleting this language may be inconsistent with the intent of the bill.

On line 291, the term "registrant" is used regarding the payment of a fee upon application to register. The context indicates that the term "registrant" should be replaced with the term "applicant."

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[30] For example, a law which retroactively criminalizes a vested legal right, such as the right to marriage, would be considered unconstitutional. Similarly, a zoning law which retroactively prohibits the use of real property is unconstitutional if the right to that particular use had previously vested in the owner.

[31] *See City of Lakeland v. Cantinella*, 129 So.2d 133 (Fla. 1961); *see also Smiley v. State*, 966 So.2d 330 (Fla. 2007); *City of Orlando v. Desjardins*, 493 So.2d 1027 (Fla. 1986).

[32] *Id.*

[33] *See Lowry v. Parole and Probation Commission*, 473 So.2d 1248 (Fla. 1985).

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to unclaimed property; amending s.
3 45.034, F.S.; revising qualifications for a surplus
4 trustee; amending s. 717.101, F.S.; revising and
5 providing definitions; creating s. 717.1235, F.S.;
6 providing that certain unclaimed property shall
7 escheat to the state for certain purposes; amending s.
8 717.1243, F.S.; revising the aggregate value that
9 constitutes a small estate account; amending s.
10 717.1333, F.S.; revising requirements for the
11 estimation of certain amounts due; amending s.
12 717.135, F.S.; revising requirements for a power of
13 attorney used in the recovery of unclaimed property;
14 eliminating a maximum fee provision for such recovery;
15 revising applicability; amending s. 717.1351, F.S.;
16 revising requirements for contracts to acquire
17 ownership of or entitlement to property; deleting a
18 provision that allows certain wording on a purchase
19 agreement; repealing s. 717.1381, F.S., relating to
20 void unclaimed property powers of attorney and
21 purchase agreements; amending s. 717.1400, F.S.;
22 removing authority of certain private investigators to
23 obtain social security numbers; revising registration
24 requirements; providing retroactive applicability;
25 providing an effective date.
26

27 Be It Enacted by the Legislature of the State of Florida:
28
29 Section 1. Subsection (8) is added to section 45.034,
30 Florida Statutes, to read:
31 45.034 Qualifications and appointment of a surplus trustee
32 in foreclosure actions.—
33 (8)(a) A surplus trustee must not be an owner,
34 shareholder, officer, member, employee, or participant in more
35 than one surplus trustee company or corporation.
36 (b) Upon a finding by the Department of Financial Services
37 that a surplus trustee has violated this subsection, the surplus
38 trustee's certification shall be suspended for 1 year.
39 Section 2. Subsection (24) of section 717.101, Florida
40 Statutes, is renumbered as subsection (25), a new subsection
41 (24) is added to that section, and subsections (4), (8), and
42 (13) of that section are amended, to read:
43 717.101 Definitions.—As used in this chapter, unless the
44 context otherwise requires:
45 (4) "Business association" means any corporation (other
46 than a public corporation), joint stock company, investment
47 company, business trust, partnership, limited liability company,
48 or association of two or more individuals for business purposes
49 ~~of two or more individuals~~, whether ~~or not~~ for profit or not for
50 profit~~, including a banking organization, financial~~
51 ~~organization, insurance company, dissolved pension plan, or~~
52 ~~utility~~.

53 (8) "Domicile" means the state of incorporation for~~, in~~
54 ~~the case of~~ a corporation incorporated under the laws of a
55 state, ~~and~~ or the state where ~~of~~ the principal place of business
56 is located for unincorporated business associations~~, in the case~~
57 ~~of a person not incorporated under the laws of a state~~.
58 (13) "Insurance company" means an association,
59 corporation, or fraternal or mutual benefit organization,
60 whether ~~or not~~ for profit or not for profit, which is engaged in
61 providing insurance coverage~~, including, by way of illustration~~
62 ~~and not limitation, accident, burial, casualty, credit life,~~
63 ~~contract performance, dental, fidelity, fire, health,~~
64 ~~hospitalization, illness, life (including endowments and~~
65 ~~annuities), malpractice, marine, mortgage, surety, and wage~~
66 ~~protection insurance~~.
67 (24) "United States" means any state, district,
68 commonwealth, territory, insular possession, and any other area
69 subject to the legislative authority of the United States of
70 America.
71 Section 3. Section 717.1235, Florida Statutes, is created
72 to read:
73 717.1235 Candidate for public office; escheatment of
74 unclaimed property.—If the apparent owner of unclaimed property
75 is the campaign account of a candidate for public office, the
76 property, after being reported to the department, shall escheat
77 to the state. The proceeds from disposition of the property
78 shall be paid into the State School Fund.

79 Section 4. Subsection (4) of section 717.1243, Florida
80 Statutes, is amended to read:
81 717.1243 Small estate accounts.—
82 (4) This section only applies if all of the unclaimed
83 property held by the department on behalf of the owner has an
84 aggregate value of $10,000 ~~$5,000~~ or less and no probate
85 proceeding is pending.
86 Section 5. Subsection (2) of section 717.1333, Florida
87 Statutes, is amended to read:
88 717.1333 Evidence; estimations; audit reports, examiner's
89 worksheets, investigative reports, other related documents.—
90 (2) If the records of the holder that are available for
91 the periods subject to this chapter are insufficient to permit
92 the preparation of a report of the unclaimed property due and
93 owing by a holder, or if the holder fails to provide records
94 after being requested to do so, the amount due to the department
95 may be reasonably estimated, regardless of whether the holder is
96 incorporated, formed, or organized in this state.
97 Section 6. Subsection (2) of section 717.135, Florida
98 Statutes, is amended to read:
99 717.135 Power of attorney to recover reported property in
100 the custody of the department.—
101 (2) A power of attorney described in subsection (1) must:
102 (a) Limit the fees and costs for services to 20 percent
103 per unclaimed property account held by the department. Fees and
104 costs for cash accounts shall be based on the value of the

105 property at the time the power of attorney is signed by the
106 claimant. Fees and costs for accounts containing securities or
107 other intangible ownership interests, which securities or
108 interests are not converted to cash, shall be based on the
109 purchase price of the security as quoted on a national exchange
110 or other market on which the property is regularly traded at the
111 time the securities or other ownership interest is remitted to
112 the claimant or the claimant's representative. Fees and costs
113 for tangible property or safe-deposit box accounts shall be
114 based on the value of the tangible property or contents of the
115 safe-deposit box at the time the ownership interest is
116 transferred or remitted to the claimant~~. Total fees and costs on~~
117 ~~any single account owned by a natural person residing in this~~
118 ~~country must not exceed $1,000~~; or
119 (b) Fully disclose that the property is held by the Bureau
120 of Unclaimed Property of the Department of Financial Services
121 pursuant to this chapter, the mailing address of the bureau, the
122 Internet address of the bureau, the person or name of the entity
123 that held the property prior to the property becoming unclaimed,
124 the date of the holder's last contact with the owner, if known,
125 and the approximate value of the property, and identify which of
126 the following categories of unclaimed property the claimant's
127 representative is seeking to recover, as reported by the holder:
128 1. Cash accounts.
129 2. Stale dated checks.
130 3. Life insurance or annuity contract assets.

131 4. Utility deposits.
132 5. Securities or other interests in business associations.
133 6. Wages.
134 7. Accounts receivable.
135 8. Contents of safe-deposit boxes.
136
137 ~~This subsection shall not apply if probate proceedings must be~~
138 ~~initiated on behalf of the claimant for an estate that has never~~
139 ~~been probated or if the unclaimed property is being claimed by a~~
140 ~~person outside of the United States.~~
141 Section 7. Paragraph (a) of subsection (2) and paragraph
142 (d) of subsection (7) of section 717.1351, Florida Statutes, are
143 amended to read:
144 717.1351 Acquisition of unclaimed property.—
145 (2) All contracts to acquire ownership of or entitlement
146 to unclaimed property from the person or persons entitled to the
147 unclaimed property must be in 10-point type or greater and must:
148 (a) Have a purchase price that discounts the value of the
149 unclaimed property at the time the agreement is executed by the
150 seller at no greater than 20 percent per account held by the
151 department~~. An unclaimed property account must not be discounted~~
152 ~~in excess of $1,000. However, the $1,000 discount limitation~~
153 ~~does not apply if probate proceedings must be initiated on~~
154 ~~behalf of the seller for an estate that has never been probated~~
155 ~~or if the seller of the unclaimed property is not a natural~~
156 ~~person or is a person outside the United States~~; or

157 (7) This section does not prohibit the:
158 ~~(d) Deletion of the words "Percent of Property to be Paid~~
159 ~~to Buyer," if the purchase agreement provides for a flat fee to~~
160 ~~be paid as compensation to the buyer.~~
161 Section 8. Section 717.1381, Florida Statutes, is
162 repealed.
163 Section 9. Section 717.1400, Florida Statutes, is amended
164 to read:
165 717.1400 Registration.—
166 (1) In order to file claims as a claimant's
167 representative, acquire ownership of or entitlement to unclaimed
168 property, receive a distribution of fees and costs from the
169 department, and obtain unclaimed property dollar amounts and~~,~~
170 numbers of reported shares of stock~~, and social security numbers~~
171 held by the department, a private investigator holding a Class
172 "C" individual license under chapter 493 must register with the
173 department on such form as the department prescribes ~~shall~~
174 ~~prescribe~~ by rule~~,~~ and must be verified by the applicant. To
175 register with the department, a private investigator must
176 provide:
177 (a) A legible copy of the applicant's Class "A" business
178 license under chapter 493 or that of the applicant's firm or
179 employer which holds a Class "A" business license under chapter
180 493.
181 (b) A legible copy of the applicant's Class "C" individual
182 license issued under chapter 493.

183 (c) The business address and telephone number of the
184 applicant's private investigative firm or employer.
185 (d) The names of agents or employees, if any, who are
186 designated to act on behalf of the private investigator,
187 together with a legible copy of their photo identification
188 issued by an agency of the United States, or a state, or a
189 political subdivision thereof.
190 (e) Sufficient information to enable the department to
191 disburse funds by electronic funds transfer.
192 (f) The tax identification number of the private
193 investigator's firm or employer which holds a Class "A" business
194 license under chapter 493.
195 (2) In order to file claims as a claimant's
196 representative, acquire ownership of or entitlement to unclaimed
197 property, receive a distribution of fees and costs from the
198 department, and obtain unclaimed property dollar amounts and~~,~~
199 numbers of reported shares of stock~~, and social security numbers~~
200 held by the department, a Florida-certified public accountant
201 must register with the department on such form as the department
202 prescribes ~~shall prescribe~~ by rule~~,~~ and must be verified by the
203 applicant. To register with the department, a Florida-certified
204 public accountant must provide:
205 (a) The applicant's Florida Board of Accountancy number.
206 (b) A legible copy of the applicant's current driver
207 license showing the full name and current address of such
208 person. If a current driver license is not available, another

209 form of identification showing the full name and current address
210 of such person or persons shall be filed with the department.
211 (c) The business address and telephone number of the
212 applicant's public accounting firm or employer.
213 (d) The names of agents or employees, if any, who are
214 designated to act on behalf of the Florida-certified public
215 accountant, together with a legible copy of their photo
216 identification issued by an agency of the United States, or a
217 state, or a political subdivision thereof.
218 (e) Sufficient information to enable the department to
219 disburse funds by electronic funds transfer.
220 (f) The tax identification number of the accountant's
221 public accounting firm employer.
222 (3) In order to file claims as a claimant's
223 representative, acquire ownership of or entitlement to unclaimed
224 property, receive a distribution of fees and costs from the
225 department, and obtain unclaimed property dollar amounts and~~,~~
226 numbers of reported shares of stock~~, and social security numbers~~
227 held by the department, an attorney licensed to practice in this
228 state must register with the department on such form as the
229 department prescribes ~~shall prescribe~~ by rule~~,~~ and must be
230 verified by the applicant. To register with the department, such
231 attorney must provide:
232 (a) The applicant's Florida Bar number.
233 (b) A legible copy of the applicant's current driver
234 license showing the full name and current address of such

235 person. If a current driver license is not available, another
236 form of identification showing the full name and current address
237 of such person or persons shall be filed with the department.
238 (c) The business address and telephone number of the
239 applicant's firm or employer.
240 (d) The names of agents or employees, if any, who are
241 designated to act on behalf of the attorney, together with a
242 legible copy of their photo identification issued by an agency
243 of the United States, or a state, or a political subdivision
244 thereof.
245 (e) Sufficient information to enable the department to
246 disburse funds by electronic funds transfer.
247 (f) The tax identification number of the attorney's firm
248 or employer.
249 (4) Information and documents already on file with the
250 department before ~~prior to~~ the effective date of this provision
251 need not be resubmitted in order to complete the registration.
252 (5) If a material change in the status of a registration
253 occurs, a registrant must, within 30 days, provide the
254 department with the updated documentation and information in
255 writing. Material changes include, but are not limited to: a
256 designated agent or employee ceasing to act on behalf of the
257 designating person, a surrender, suspension, or revocation of a
258 license, or a license renewal.
259 (a) If a designated agent or employee ceases to act on
260 behalf of the person who has designated the agent or employee to

261 act on such person's behalf, the designating person must, within
262 30 days, inform the Bureau of Unclaimed Property in writing of
263 the termination of agency or employment.
264 (b) If a registrant surrenders the registrant's license or
265 the license is suspended or revoked, the registrant must, within
266 30 days, inform the bureau in writing of the surrender,
267 suspension, or revocation.
268 (c) If a private investigator's Class "C" individual
269 license under chapter 493 or a private investigator's employer's
270 Class "A" business license under chapter 493 is renewed, the
271 private investigator must provide a copy of the renewed license
272 to the department within 30 days after the receipt of the
273 renewed license by the private investigator or the private
274 investigator's employer.
275 (6) A registrant's firm or employer may not have a name
276 that might lead another person to conclude that the registrant's
277 firm or employer is affiliated or associated with the United
278 States, or an agency thereof, or a state or an agency or
279 political subdivision of a state. The department shall deny an
280 application for registration or revoke a registration if the
281 applicant's or registrant's firm or employer has a name that
282 might lead another person to conclude that the firm or employer
283 is affiliated or associated with the United States, or an agency
284 thereof, or a state or an agency or political subdivision of a
285 state. Names that might lead another person to conclude that the
286 firm or employer is affiliated or associated with the United

287 States, or an agency thereof, or a state or an agency or
288 political subdivision of a state, include, but are not limited
289 to, the words United States, Florida, state, bureau, division,
290 department, or government.
291 (7) A registrant must submit a $500 application fee with
292 his or her application for registration and submit a $250
293 renewal fee on or before July 1 of each year thereafter. A
294 registrant who fails to pay the renewal fee shall lose
295 privileges afforded by this section until his or her fees are
296 paid. A registrant who fails to renew his or her registration by
297 December 31 must reapply for registration.
298 (8) ~~(7)~~ The licensing and other requirements of this
299 section must be maintained as a condition of registration with
300 the department.
301 Section 10. The amendments made by this act to s.
302 717.1333, Florida Statutes, are remedial in nature and apply
303 retroactively to unclaimed property existing before July 1,
304 2016.
305 Section 11. This act shall take effect July 1, 2016.

Insurance & Banking Subcommittee

HB 783 by Rep. Trumbull
Unclaimed Property

AMENDMENT SUMMARY
February 1, 2016

Amendment 1 by Rep. Trumbull (strike-all): The amendment is a strike-all amendment. It makes the following revisions to the bill:

- Removes section 1 of the bill relating to "surplus trustees";
- Requires each court pleading filed within 180 days prior to a claim for unclaimed property to be filed with the Department of Financial Services;
- Requires identification of the percent of the recovery to be paid to the representative in all claims involving a grant of limited power of attorney, regardless of whether a flat fee payment is made;
- Requires all authorizations or agreements for representation regarding a claim for unclaimed property to meet specified requirements regarding accurate and personal completion by the claimant;
- Authorizes DFS to deny the claim for exceeding the fee cap on the representative's or purchaser's compensation;
- Increases the maximum number of days for a claimant to be paid following a purchase agreement from 10 days to 30 days from the date of execution and voiding the claim if proof of payment is not filed with the DFS;
- Restores a statement of legislative intent;
- Removes the section of the bill that expressed intent to apply a portion of the bill retroactively; and
- Certain other technical, grammatical or clarifying revisions.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

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1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Trumbull offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Subsection (24) of section 717.101, Florida
8 Statutes, is renumbered as subsection (25), subsections (4),
9 (8), and (13) of that section are amended, and a new subsection
10 (24) is added to that section, to read:
11 717.101 Definitions.—As used in this chapter, unless the
12 context otherwise requires:
13 (4) "Business association" means any corporation (other
14 than a public corporation), joint stock company, investment
15 company, business trust, partnership, limited liability company,
16 or association of two or more individuals for business purposes
17 ~~of two or more individuals~~, whether ~~or not~~ for profit or not for

18 profit~~, including a banking organization, financial~~
19 ~~organization, insurance company, dissolved pension plan, or~~
20 ~~utility~~.
21 (8) "Domicile" means the state of incorporation for~~, in~~
22 ~~the case of~~ a corporation incorporated under the laws of a
23 state, ~~and~~ or, for an unincorporated business association, the
24 state where ~~of~~ the ~~principal place of~~ business association is
25 organized~~, in the case of a person not incorporated under the~~
26 ~~laws of a state~~.
27 (13) "Insurance company" means an association,
28 corporation, or fraternal or mutual benefit organization,
29 whether ~~or not~~ for profit or not for profit, which is engaged in
30 providing insurance coverage~~, including, by way of illustration~~
31 ~~and not limitation, accident, burial, casualty, credit life,~~
32 ~~contract performance, dental, fidelity, fire, health,~~
33 ~~hospitalization, illness, life (including endowments and~~
34 ~~annuities), malpractice, marine, mortgage, surety, and wage~~
35 ~~protection insurance~~.
36 (24) "United States" means any state, district,
37 commonwealth, territory, insular possession, and any other area
38 subject to the legislative authority of the United States of
39 America.
40 Section 2. Section 717.1235, Florida Statutes, is created
41 to read:
42 717.1235 Dormant campaign accounts; report of unclaimed
43 property.—Unclaimed funds reported in the name of a campaign for

44 public office, for any campaign that must dispose of surplus
45 funds in its campaign account pursuant to s. 106.141, after
46 being reported to the department, shall be deposited with the
47 Chief Financial Officer to the credit of the State School Fund.
48 Section 3. Subsection (4) of section 717.1243, Florida
49 Statutes, is amended to read:
50 717.1243 Small estate accounts.—
51 (4) This section only applies if all of the unclaimed
52 property held by the department on behalf of the owner has an
53 aggregate value of $10,000 ~~$5,000~~ or less and no probate
54 proceeding is pending.
55 Section 4. Section 717.1262, Florida Statutes, is amended
56 to read:
57 717.1262 Court documents.—Any person who claims
58 entitlement to unclaimed property by reason of a court document
59 shall file a certified copy of the court document with the
60 department. A certified copy of each pleading filed with the
61 court to obtain a court document establishing entitlement, filed
62 within 180 days before the date the claim form was signed by the
63 claimant or claimant's representative, must also be filed with
64 the department.
65 Section 5. Subsection (2) of section 717.1333, Florida
66 Statutes, is amended to read:
67 717.1333 Evidence; estimations; audit reports, examiner's
68 worksheets, investigative reports, other related documents.—

69 (2) If the records of the holder that are available for
70 the periods subject to this chapter are insufficient to permit
71 the preparation of a report of the unclaimed property due and
72 owing by a holder, or if the holder fails to provide records
73 after being requested to do so, the amount due to the department
74 may be reasonably estimated.
75 Section 6. Subsections (5) and (6) of section 717.135,
76 Florida Statutes, are renumbered as subsections (6) and (7),
77 respectively, subsection (2) and paragraph (g) of subsection (4)
78 of that section are amended, and a new subsection (5) is added
79 to that section, to read:
80 717.135 Power of attorney to recover reported property in
81 the custody of the department.—
82 (2) A power of attorney described in subsection (1) must:
83 (a) Limit the fees and costs for services to 20 percent
84 per unclaimed property account held by the department. Fees and
85 costs for cash accounts shall be based on the value of the
86 property at the time the power of attorney is signed by the
87 claimant. Fees and costs for accounts containing securities or
88 other intangible ownership interests, which securities or
89 interests are not converted to cash, shall be based on the
90 purchase price of the security as quoted on a national exchange
91 or other market on which the property is regularly traded at the
92 time the securities or other ownership interest is remitted to
93 the claimant or the claimant's representative. Fees and costs
94 for tangible property or safe-deposit box accounts shall be

95 based on the value of the tangible property or contents of the
96 safe-deposit box at the time the ownership interest is
97 transferred or remitted to the claimant~~. Total fees and costs on~~
98 ~~any single account owned by a natural person residing in this~~
99 ~~country must not exceed $1,000~~; or
100 (b) Fully disclose that the property is held by the Bureau
101 of Unclaimed Property of the Department of Financial Services
102 pursuant to this chapter, the mailing address of the bureau, the
103 Internet address of the bureau, the person or name of the entity
104 that held the property prior to the property becoming unclaimed,
105 the date of the holder's last contact with the owner, if known,
106 and the approximate value of the property, and identify which of
107 the following categories of unclaimed property the claimant's
108 representative is seeking to recover, as reported by the holder:
109 1. Cash accounts.
110 2. Stale dated checks.
111 3. Life insurance or annuity contract assets.
112 4. Utility deposits.
113 5. Securities or other interests in business associations.
114 6. Wages.
115 7. Accounts receivable.
116 8. Contents of safe-deposit boxes.
117
118 ~~This subsection shall not apply if probate proceedings must be~~
119 ~~initiated on behalf of the claimant for an estate that has never~~

120 ~~been probated or if the unclaimed property is being claimed by a~~
121 ~~person outside of the United States.~~
122 (4)(g) This section does not prohibit the:
123 1. Use of bolding, italics, print of different colors, and
124 text borders as a means of highlighting or stressing certain
125 selected items within the text.
126 2. Placement of the name, address, and telephone number of
127 the representative's firm or company in the top margin above the
128 words "POWER OF ATTORNEY." No additional writing of any kind may
129 be placed in the top margin including, but not limited to,
130 logos, license numbers, Internet addresses, or slogans.
131 3. Placement of the word "pending" prior to the words "NET
132 AMOUNT TO BE PAID TO CLAIMANT," if it is not yet possible to
133 determine the percentage interest of an heir or legatee prior to
134 a determination on the issue by the probate court.
135 4. Deletion of the words "Number of Shares of Stock (If
136 Applicable)" if the agreement does not relate to the recovery of
137 securities.
138 ~~5. Deletion of the words "Percent to Be Paid as~~
139 ~~Compensation to Claimant's Representative" if the power of~~
140 ~~attorney provides for a flat fee to be paid as compensation to~~
141 ~~the claimant's representative.~~
142 (5)(a) Any other authorization or agreement to recover
143 unclaimed property executed by or between a claimant's
144 representative and the claimant must be signed and personally
145 dated by the claimant. The date affixed on any such

146 authorization or agreement by the claimant may not be earlier
147 than the date personally affixed by the claimant on the original
148 limited power of attorney as provided by this chapter. A copy of
149 the authorization or agreement must be filed with the original
150 claim submitted to the department, along with the original power
151 of attorney, as provided by this chapter.
152 (b) If the claimant's representative's fee for a document
153 described in this subsection exceeds 20 percent on any given
154 claim, s. 717.124(1)(d) applies.
155 Section 7. Paragraph (a) of subsection (2), subsection
156 (4), and paragraph (d) of subsection (7) of section 717.1351,
157 Florida Statutes, are amended, subsection (8) is renumbered as
158 subsection (9), and a new subsection (8) is added to that
159 section, to read:
160 717.1351 Acquisition of unclaimed property.—
161 (2) All contracts to acquire ownership of or entitlement
162 to unclaimed property from the person or persons entitled to the
163 unclaimed property must be in 10-point type or greater and must:
164 (a) Have a purchase price that discounts the value of the
165 unclaimed property at the time the agreement is executed by the
166 seller at no greater than 20 percent per account held by the
167 department~~. An unclaimed property account must not be discounted~~
168 ~~in excess of $1,000. However, the $1,000 discount limitation~~
169 ~~does not apply if probate proceedings must be initiated on~~
170 ~~behalf of the seller for an estate that has never been probated~~

171 ~~or if the seller of the unclaimed property is not a natural~~
172 ~~person or is a person outside the United States~~; or
173 (4) Any contract to acquire ownership of or entitlement to
174 unclaimed property from the person or persons entitled to the
175 unclaimed property must provide for the purchase price to be
176 remitted to the seller or sellers within 30 ~~10~~ days after the
177 execution of the contract by the seller or sellers. The contract
178 must specify the unclaimed property account number, the name of
179 the holder who reported the property to the department, the
180 category of unclaimed property, the value of the unclaimed
181 property account, and the number of shares of stock, if
182 applicable. Proof that the seller has received ~~of~~ payment by
183 check must be filed with the department with the claim. If proof
184 of payment is not provided, the claim is void.
185 (7) This section does not prohibit the:
186 ~~(d) Deletion of the words "Percent of Property to be Paid~~
187 ~~to Buyer," if the purchase agreement provides for a flat fee to~~
188 ~~be paid as compensation to the buyer.~~
189 (8)(a) Any other authorization or agreement to purchase
190 unclaimed property executed by or between a registrant and a
191 seller must be signed and personally dated by the seller. The
192 date affixed on any such authorization or agreement by the
193 seller may not be earlier than the date personally affixed by
194 the seller on the original purchase agreement as provided by
195 this chapter. A copy of the authorization or agreement must be
196 filed with the original claim submitted to the department, along

197 with the original purchase agreement, as provided by this
198 chapter.
199 (b) If the registrant's purchase fee for a document
200 described in this subsection reduces the seller's purchase price
201 amount by more than 20 percent on any given claim, s.
202 717.124(1)(d) applies.
203 Section 8. Section 717.1381, Florida Statutes, is
204 repealed.
205 Section 9. Section 717.139, Florida Statutes, is amended
206 to read:
207 717.139 Uniformity of application and construction.—
208 (1) It is the public policy of the state to protect the
209 interests of owners of unclaimed property. It is declared to be
210 in the best interests of owners of unclaimed property that such
211 owners receive the full amount of any unclaimed property without
212 any fee.
213 (2) This chapter shall be applied and construed as to
214 effectuate its general purpose of protecting the interest of
215 missing owners of property, while providing that the benefit of
216 all unclaimed and abandoned property shall go to all the people
217 of the state, and to make uniform the law with respect to the
218 subject of this chapter among states enacting it.
219 Section 10. Section 717.1400, Florida Statutes, is amended
220 to read:
221 717.1400 Registration.—

222 (1) In order to file claims as a claimant's
223 representative, acquire ownership of or entitlement to unclaimed
224 property, receive a distribution of fees and costs from the
225 department, and obtain unclaimed property dollar amounts and~~,~~
226 numbers of reported shares of stock~~, and social security numbers~~
227 held by the department, a private investigator holding a Class
228 "C" individual license under chapter 493 must register with the
229 department on such form as the department prescribes ~~shall~~
230 ~~prescribe~~ by rule~~,~~ and must be verified by the applicant. To
231 register with the department, a private investigator must
232 provide:
233 (a) A legible copy of the applicant's Class "A" business
234 license under chapter 493 or that of the applicant's firm or
235 employer which holds a Class "A" business license under chapter
236 493.
237 (b) A legible copy of the applicant's Class "C" individual
238 license issued under chapter 493.
239 (c) The business address and telephone number of the
240 applicant's private investigative firm or employer.
241 (d) The names of agents or employees, if any, who are
242 designated to act on behalf of the private investigator,
243 together with a legible copy of their photo identification
244 issued by an agency of the United States, or a state, or a
245 political subdivision thereof.
246 (e) Sufficient information to enable the department to
247 disburse funds by electronic funds transfer.

248 (f) The tax identification number of the private
249 investigator's firm or employer which holds a Class "A" business
250 license under chapter 493.
251 (2) In order to file claims as a claimant's
252 representative, acquire ownership of or entitlement to unclaimed
253 property, receive a distribution of fees and costs from the
254 department, and obtain unclaimed property dollar amounts and~~,~~
255 numbers of reported shares of stock~~, and social security numbers~~
256 held by the department, a Florida-certified public accountant
257 must register with the department on such form as the department
258 prescribes ~~shall prescribe~~ by rule~~,~~ and must be verified by the
259 applicant. To register with the department, a Florida-certified
260 public accountant must provide:
261 (a) The applicant's Florida Board of Accountancy number.
262 (b) A legible copy of the applicant's current driver
263 license showing the full name and current address of such
264 person. If a current driver license is not available, another
265 form of identification showing the full name and current address
266 of such person or persons shall be filed with the department.
267 (c) The business address and telephone number of the
268 applicant's public accounting firm or employer.
269 (d) The names of agents or employees, if any, who are
270 designated to act on behalf of the Florida-certified public
271 accountant, together with a legible copy of their photo
272 identification issued by an agency of the United States, or a
273 state, or a political subdivision thereof.

274 (e) Sufficient information to enable the department to
275 disburse funds by electronic funds transfer.
276 (f) The tax identification number of the accountant's
277 public accounting firm employer.
278 (3) In order to file claims as a claimant's
279 representative, acquire ownership of or entitlement to unclaimed
280 property, receive a distribution of fees and costs from the
281 department, and obtain unclaimed property dollar amounts and~~,~~
282 numbers of reported shares of stock~~, and social security numbers~~
283 held by the department, an attorney licensed to practice in this
284 state must register with the department on such form as the
285 department prescribes ~~shall prescribe~~ by rule~~,~~ and must be
286 verified by the applicant. To register with the department, such
287 attorney must provide:
288 (a) The applicant's Florida Bar number.
289 (b) A legible copy of the applicant's current driver
290 license showing the full name and current address of such
291 person. If a current driver license is not available, another
292 form of identification showing the full name and current address
293 of such person or persons shall be filed with the department.
294 (c) The business address and telephone number of the
295 applicant's firm or employer.
296 (d) The names of agents or employees, if any, who are
297 designated to act on behalf of the attorney, together with a
298 legible copy of their photo identification issued by an agency

299 of the United States, or a state, or a political subdivision
300 thereof.
301 (e) Sufficient information to enable the department to
302 disburse funds by electronic funds transfer.
303 (f) The tax identification number of the attorney's firm
304 or employer.
305 (4) Information and documents already on file with the
306 department before ~~prior to~~ the effective date of this provision
307 need not be resubmitted in order to complete the registration.
308 (5) If a material change in the status of a registration
309 occurs, a registrant must, within 30 days, provide the
310 department with the updated documentation and information in
311 writing. Material changes include, but are not limited to: a
312 designated agent or employee ceasing to act on behalf of the
313 designating person, a surrender, suspension, or revocation of a
314 license, or a license renewal.
315 (a) If a designated agent or employee ceases to act on
316 behalf of the person who has designated the agent or employee to
317 act on such person's behalf, the designating person must, within
318 30 days, inform the Bureau of Unclaimed Property in writing of
319 the termination of agency or employment.
320 (b) If a registrant surrenders the registrant's license or
321 the license is suspended or revoked, the registrant must, within
322 30 days, inform the bureau in writing of the surrender,
323 suspension, or revocation.

324 (c) If a private investigator's Class "C" individual
325 license under chapter 493 or a private investigator's employer's
326 Class "A" business license under chapter 493 is renewed, the
327 private investigator must provide a copy of the renewed license
328 to the department within 30 days after the receipt of the
329 renewed license by the private investigator or the private
330 investigator's employer.
331 (6) A registrant's firm or employer may not have a name
332 that might lead another person to conclude that the registrant's
333 firm or employer is affiliated or associated with the United
334 States, or an agency thereof, or a state or an agency or
335 political subdivision of a state. The department shall deny an
336 application for registration or revoke a registration if the
337 applicant's or registrant's firm or employer has a name that
338 might lead another person to conclude that the firm or employer
339 is affiliated or associated with the United States, or an agency
340 thereof, or a state or an agency or political subdivision of a
341 state. Names that might lead another person to conclude that the
342 firm or employer is affiliated or associated with the United
343 States, or an agency thereof, or a state or an agency or
344 political subdivision of a state, include, but are not limited
345 to, the words United States, Florida, state, bureau, division,
346 department, or government.
347 (7) A registrant must submit a $500 application fee with
348 his or her application for registration and submit a $250
349 renewal fee on or before July 1 of each year thereafter. A

350 registrant who fails to pay the renewal fee shall lose
351 privileges afforded by this section until his or her fees are
352 paid. A registrant who fails to renew his or her registration by
353 December 31 must reapply for registration.
354 (8) ~~(7)~~ The licensing and other requirements of this
355 section must be maintained as a condition of registration with
356 the department.
357 Section 11. This act shall take effect July 1, 2016.
358
359 ----------
360 **T I T L E A M E N D M E N T**
361 Remove everything before the enacting clause and insert:
362 A bill to be entitled
363 An act relating to unclaimed property; amending s.
364 717.101, F.S.; revising and providing definitions;
365 creating s. 717.1235, F.S.; requiring certain
366 unclaimed funds to be deposited with the Chief
367 Financial Officer for certain purposes; amending s.
368 717.1243, F.S.; revising the aggregate value that
369 constitutes a small estate account; amending s.
370 717.1262, F.S.; requiring a copy of certain pleadings
371 to be filed with the Department of Financial Services;
372 amending s. 717.1333, F.S.; revising requirements for
373 the estimation of certain amounts due to the
374 department; amending s. 717.135, F.S.; revising
375 requirements for a power of attorney used in the

376 recovery of unclaimed property; eliminating a maximum
377 fee provision for such recovery; revising
378 applicability; deleting a provision that allows
379 deletion of certain wording from a power of attorney;
380 providing requirements for certain authorizations and
381 agreements to recover unclaimed property; amending s.
382 717.1351, F.S.; revising requirements for contracts to
383 acquire ownership of or entitlement to property;
384 providing that certain claims are void; deleting a
385 provision that allows deletion of certain wording from
386 a purchase agreement; providing requirements for
387 certain authorizations and agreements to purchase
388 unclaimed property; repealing s. 717.1381, F.S.,
389 relating to void unclaimed property powers of attorney
390 and purchase agreements; amending s. 717.139, F.S.;
391 providing a statement of public policy; amending s.
392 717.1400, F.S.; removing authority of certain private
393 investigators, accountants, and attorneys to obtain
394 social security numbers; providing an effective date.

HB 897

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 897 Service of Process on Financial Institutions
SPONSOR(S): Stone
TIED BILLS: **IDEN./SIM. BILLS:** SB 1104

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Bauer	Luczynski
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

The Office of Financial Regulation (OFR), which is administratively housed within the Department of Financial Services (DFS), is responsible for the regulation of financial institutions chartered and organized under Florida law and in accordance with the Florida Financial Institutions Codes (Codes) for safety and soundness. The OFR does not regulate financial institutions that are chartered under federal law or in other states, although these non-Florida financial institutions that transact business in Florida are still subject to certain state laws, including service of process laws.

Currently, s. 655.0201, F.S., governs the manner in which service of process, notice, or demand may be made on financial institutions that transact business in Florida, whether state or nationally chartered. It provides that process may be served in accordance with any of the following:

- *Chs. 48 and 49, F.S.* (relating to service of process and constructive service of process):
  - Provisions in ch. 48, F.S., designate the Secretary of State of Florida to serve as the agent for foreign business entities doing business in Florida and for domestic LLCs under certain circumstances. The Department of State (DOS)'s Division of Corporations currently maintains corporate registered agent information through its website, www.sunbiz.org.
- *Ch. 605, F.S. or Pt. I, Ch. 607, F.S.* (LLC and corporation law):
  Because the Codes require Florida-chartered banks to be formed as a Florida corporation or as a LLC in certain circumstances, s. 655.0201(1), F.S., also allows service of process to be made on financial institutions pursuant to ch. 605, F.S. (Florida Revised Limited Liability Company Act), or part I of ch. 607, F.S. (Florida Business Corporation Act). Foreign corporations may generally be served process through its registered agent.
- However, if the financial institution does not have a registered agent, or the registered agent cannot be served with reasonable diligence, the statute authorizes service on any *executive officer* of the financial institution at its principal place of business in Florida.

The bill amends s. 655.0201, F.S., to revise the ways in which service of process may be made upon a financial institution, whether state- or nationally-chartered. The bill also authorizes a financial institution to designate a central location in Florida for service of process, requires the institution to file a notice with the DFS in order to establish a central location for service of process, and requires the DFS to publish and maintain a list of all central locations on its agency website.

The bill has no impact on local governments. The bill has an indeterminate but negative impact on state government and the private sector, in that the bill requires new duties for the DFS, and may result in additional costs for litigants due to ambiguity created by the bill regarding the proper method to serve process on a financial institution in Florida.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

The U.S. Dual Banking System

The U.S. dual banking system allows financial institutions to become chartered (organized) under either federal or state law.

- *National banks* are chartered under federal law, i.e., the National Bank Act,[1] and are supervised by the Office of the Comptroller of the Currency (OCC), which is housed with the U.S. Department of the Treasury.
- *State-chartered banks* are chartered under the laws of the state in which the bank is headquartered.
- *Credit unions* may also be either state or federally chartered.

In Florida, the Office of Financial Regulation (OFR), which is administratively housed within the Department of Financial Services (DFS), is responsible for the regulation of financial institutions chartered and organized under Florida law and in accordance with the Florida Financial Institutions Codes (Codes) and commission rules[2] for safety and soundness. The OFR does not regulate national banks and banks that are chartered and regulated in other states. In addition, the OFR does not regulate institutions that are chartered and regulated by foreign institutions, except to the extent those foreign institutions seek to engage in the business of banking or trust business in Florida.

While a financial institution may elect to be state-chartered, it is still subject to federal regulation. The U.S. dual banking system is premised on two related doctrines - the competitive equality doctrine and federal preemption. The competitive equality doctrine essentially states that national banks are subject to state laws with regards to their daily course of business, such as their acquisition and transfer of property, their right to collect their debts and their liability to be sued for debts, contracts, usury, and trust powers.[3] However, while states are generally free to legislate on matters not controlled by federal regulation, the application of state laws to national banks is subject to the preemption doctrine. By operation of the U.S. Constitution's Supremacy Clause,[4] federal regulation of a particular subject preempts state regulation related to the same subject.[5]

OCC regulations provide that a nationally chartered bank may exercise its deposit-taking and lending powers *without regard* to state law limitations on certain matters, such as checking accounts, disclosure requirements, and state licensing and registration requirements, meaning these state laws are preempted. However, the regulations specifically exclude state licensing or registration requirements

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[1] The National Bank Act of 1964 (12 U.S.C. § 24 Seventh) gives enumerated powers and "all such incidental powers as shall be necessary to carry on the business of banking" to nationally chartered banks.

[2] s. 20.121(3)(a)2. and (e), F.S. The Codes consist of ch. 655 (financial institutions generally); ch. 657 (credit unions); ch. 658 (banks and trust companies); ch. 660 (trust business); ch. 663 (international banking); ch. 665 (capital stock associations); and ch. 665 (savings associations).

[3] *National Bank v. Commonwealth*, 9 Wall. 353, 362, 19 L.Ed. 701(1870).

[4] U.S. Const., Art. VI, cl. 2.

[5] In *Barnett Bank of Marion County, N.A. v. Nelson*, 517 U.S. 25 (1996), for instance, the U.S. Supreme Court held that a federal statute granting small town banks the authority to sell insurance, preempted a Florida statute which prohibited such sales. The federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 codified the test for "conflict preemption" articulated in the *Barnett Bank* decision. The conflict preemption test asks whether the state law prevents or significantly interferes with the exercise by the national bank's powers. *See* 12 U.S.C. §25b(b)(1).

"for purposes of service of process," meaning that state service of process laws may apply to national banks and are not preempted by federal law.[6]

Service of Process on Financial Institutions in Florida Under the Codes

Currently, s. 655.0201, F.S., governs the manner in which service of process, notice, or demand may be made on financial institutions that transact business in Florida, whether state or nationally chartered. It provides that process may be served in accordance with any of the following:

1. *Chs. 48 and 49, F.S. (Process and Service of Process & Constructive Service of Process)*
   - Ch. 48, F.S. (Process and Service of Process):
     - In particular, s. 48.081, F.S., sets forth the order of priority of persons within a private corporation, domestic or foreign, who may be properly served: [7]
       - President or vice president, or other head of the corporation,
       - Cashier, treasurer, secretary, or general manager,
       - Any director,
       - Any officer or business agent residing in the state.
     - Provisions in ch. 48, F.S. designate the Secretary of State of Florida to serve as the agent for foreign business entities doing business in Florida and for domestic LLCs under certain circumstances. The Department of State (DOS)'s Division of Corporations currently maintains corporate registered agent information through its website, www.sunbiz.org.
     - Every Florida corporation and every foreign corporation qualified to do business in this state must designate a registered agent and registered office (which must be kept open and available for receiving process during certain hours and days), in accordance with pt. 1, ch. 607, F.S.[8]

2. *Ch. 605, F.S., or Part I, Ch. 607, F.S. (LLC and corporation law)*

Secondly, because the Codes require Florida-chartered banks to be formed as a Florida corporation or as a limited liability company (LLC) in certain circumstances,[9] s. 655.0201(1), F.S., also allows service of process to be made on financial institutions pursuant to ch. 605, F.S. (Florida Revised Limited Liability Company Act), or part I of ch. 607, F.S. (Florida Business Corporation Act).

- The LLC Act generally provides that process may be served on the entity's registered agent.[10]
- Process may generally be served on any corporation in accordance with ch. 48, F.S., or ch. 49, F.S., discussed above, while notice or demand may be made to the chair of the board of directors the president, any vice president, the secretary, the treasurer, the registered agent, or to the principal office of the corporation in Florida.[11]
- Process on foreign corporations authorized to transact business in Florida may be made on its registered agent, or in certain circumstances, to the secretary of the corporation.[12]

3. *Registered Agent, Executive Officer, or Other Designated Persons*

Thirdly, the Codes also permit financial institutions to designate a *registered agent* for service of process. However, if the financial institution does not have a registered agent, or the registered agent

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[6] 12 C.F.R. §§7.4007(a)(6) and 7.4008(d)(1).

[7] "The object of s. 48.081, F.S., is to have service made upon someone who is held responsible by the corporation, "and it contemplates that service shall be made, whenever possible, upon the more responsible officers before resorting to service upon one of the inferior officers or agents of the corporation." Imperial *Towers, Inc. v. Dade Home Servs., Inc.*, 199 So.2d 518, 520-521 (Fla. 4th DCA 1967) (citing *Cherry Lake Farms v. Love*, 129 Fla. 469, 176 486 (1937)).

[8] s. 48.091, F.S.

[9] *See* s. 658.16, F.S., relating to creation of banking or trust corporations. Credit unions authorized to transact business pursuant to Florida law are required to have one principal place of business (as designated in its bylaws) where legal process may be served. *See* s. 657.00891, F.S.

[10] ss. 605.0113 and 605.0117, F.S.

[11] s. 607.0504, F.S.

[12] s. 607.15101, F.S.

cannot be served with reasonable diligence, the statute authorizes service on any *executive officer* of the financial institution at its principal place of business in Florida. The Codes broadly define "executive officer" as:

> An individual, whether or not the individual has an official title or receives a salary or other compensation, who participates or has authority to participate, other than in the capacity of a director, in the major policymaking functions of a financial institution. The term does not include an individual who may have an official title and may exercise discretion in the performance of duties and functions, including discretion in the making of loans, but who does not participate in the determination of major policies of the financial institution and whose decisions are limited by policy standards established by other officers, whether or not the policy standards have been adopted by the board of directors.[13]

If neither of the previously described alternatives is viable, the default alternative is to serve any *officer, director, or business agent* of the financial institution at its principal place of business or at any other branch, office, or place of business in this state.

Finally, the statute provides that this section does not prescribe the only means of serving notice or demand on a financial institution.

A recent example of improper service of process on a financial institution in Florida is illustrated in the *Bank of America, N.A. v. Bornstein* decision from the Fourth District Court of Appeal. The plaintiff served a writ of garnishment on Bank of America (BOA) through a bank teller at a West Palm Beach branch office, without showing that service was first attempted on the statutorily prescribed superior classes of persons who could have been served. BOA moved to quash service under the service of process statutes in the Codes and under ch. 48, F.S., asserting that the bank teller was not authorized to accept service on behalf of the bank. The appellate court concurred with the bank, finding service was improper.[14] In instances where a financial institution does not timely move to quash defective service, it could be held liable for the underlying action, such as in garnishment proceedings.[15]

Effect of the Bill

The bill amends s. 655.0201, F.S., to revise the ways in which service of process may be made upon a financial institution, whether state- or nationally-chartered. The bill also authorizes a financial institution to designate a central location in Florida for service of process, requires the institution to file a notice with the DFS in order to establish a central location for service of process, and requires the DFS to publish and maintain a list of all central locations on its agency website.

Section 1 of the bill amends s. 655.005(1), F.S., which contains various definitions, by adding a new paragraph (h) to provide that the term "department" means Department of Financial Services.

Section 2 of the bill amends s. 655.0201, F.S., to delete the reference to service of notice or demand. The bill deletes the provisions permitting service of process on financial institutions, pursuant to ch. 48, F.S., ch. 49, F.S., ch. 605, F.S., or pt. 1, ch. 607, F.S. The existing provisions related to service of process on financial institutions are amended to require the institutions to designate a place or registered agent within the state as the institution's central location for service of process. This designated place or registered agent will be the sole location for service of process on the financial institution and all of its branches within the state. A financial institution must file notice designating its

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[13] s. 655.005(1)(g), F.S. The statute also lists presumptive examples of "executive officer," such as the chair of the board of directors, the president, the chief executive officer, etc., unless excluded by board resolution or bylaws.
[14] *Bank of America, N.A. v. Bornstein*, 39 So.3d 500 (4th DCA 2010).
[15] Ch. 77, F.S., requires the garnishee-defendant to serve an answer on the plaintiff within 20 days after service of the writ of garnishment, or be subject to a default judgment.

central location with the DFS. The notice must contain the central location's addressee name, physical address, telephone number, and business hours during which service will be accepted. Section 2 also provides that the central location is the proper venue for service of process for all types of service of process made on a financial institution, including service for actions related to garnishment, levy, injunctions, lawsuits, and the attachment of safety deposit boxes, in accordance with chs. 60, 76, and 77, F.S., and the Florida Rules of Civil Procedure.

The bill requires DFS to publish a list of all central locations on its website and update the list to reflect revocations or modifications made by a financial institution within 15 business days after receipt of such revocation or modification. The DFS's website must specify the date the list was last updated. Section 2 provides that service may be made to an officer of the financial institution at its principal place of business or at any other branch, office, or place of business in the state if service cannot be made in accordance with the process for service at the central location outlined above.

Sections 3 and 4 amend subsection 322.143(9) and paragraph 655.968(1)(b), F.S., respectively, to conform cross-references as result of the new definition added to s. 655.005, F.S.

Section 5 provides for an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1. Amends s. 655.005, F.S., relating to definitions.

Section 2. Amends s. 655.0201, F.S., relating to service of process, notice, or demand on financial institutions.

Section 3. Amends s. 322.143, F.S., relating to use of driver license or identification card.

Section 4. Amends s. 655.958, F.S., relating to financial institutions; transactions relating to Iran or terrorism.

Section 5. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The DFS noted that it will be required to dedicate resources to maintain and update the central locations list on its website for all financial institutions on an ongoing basis. Additionally, the DFS staff already fields questions and is called upon to dialogue with parties who do not understand the DFS's role for service of process under chs. 48, 624, and 626, F.S. Based on these experiences with, for example, designations of and notice to personal injury protection (PIP) contacts, ch. 768, F.S., contacts, and civil remedy notices, it is anticipated that the bill will result in additional work for staff of the DFS. It is also anticipated that the DFS will need to dedicate resources to document and respond when parties erroneously attempt to serve process on financial institutions via the DFS. Additionally, while the proposed bill establishes that the DFS would only post the central location list to serve process on financial institutions, it is anticipated that documents, services, and certified mail for financial institutions will be sent to the DFS in error, and the DFS will be expected to

document receipt, forward, and/or return the records received in error. The DFS noted that its staff is not knowledgeable of or familiar with service-related financial institution documentation.[16]

Additionally, the DOS noted the bill will increase staff time by adding another cross-check procedure against the DFS list when processing service of process requests.[17]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to the DFS and the OFR, litigants may incur additional cost because of confusion regarding the proper method to serve process on a financial institution, as the relevant information regarding service of process on corporations and other entities using fictitious names is already maintained by the Department of State, Division of Corporations, and is accessible online through their website at www.sunbiz.org if the corporation has designated a registered agent. Additionally, the DFS and the OFR noted that the bill:

- Does not identify the minimum number of business hours during which service will be accepted at the designated central location. By not defining the hours, the ability to serve a financial institution could be unduly limited and could lead to abusive practices;
- Does not provide for an alternate means of service if the designated addressee is not present at the central location is not present at the financial institution's principal place of business, branch, office, or place of business in Florida;
- Provides that an officer may be served at the principal place of business or at any other branch, office, or place of business in the state if service cannot be made at the designated central location; however, "officer" is not a term defined in the bill or in the Codes.
- Deletes the method to serve notice or demand on a financial institution, which may result in ambiguity and uncertainty regarding how a party will perfect service of notice or demand.[18]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

[16] Department of Financial Services, Agency Analysis of 2016 House Bill 897, p. 4 (Jan. 7, 2016).
[17] Department of State, Agency Analysis of 2016 House Bill 897, p. 4 (Jan. 14, 2016).
[18] DFS Agency Analysis, p. 2, and OFR Agency Analysis, p. 5.

B. RULE-MAKING AUTHORITY:

None provided by the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill appears to create a conflict with s. 20.121(3), F.S., which designates the OFR as being responsible for all activities of the Financial Services Commission relating to the regulation of banks, credit unions, other financial institutions, finance companies, and the securities industry. The conflict is created due to the use of the term "department," which is referencing the DFS, not the OFR.[19] Similarly, the DFS noted that while the OFR and the DFS share some administrative resources, requiring the DFS to publish the central locations list on the DFS website and to maintain the list would commingle the responsibilities of the two agencies in a substantive way that is not contemplated in current law.[20]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[19] OFR Agency Analysis, p. 5.
[20] DFS Agency Analysis, p. 2.

1 A bill to be entitled
2 An act relating to service of process on financial
3 institutions; amending s. 655.005, F.S.; providing a
4 definition; amending s. 655.0201, F.S.; revising
5 requirements relating to service of process on
6 financial institutions authorized by federal or state
7 law to transact business in this state; authorizing
8 financial institutions to designate a central location
9 for service of process; providing requirements;
10 providing responsibilities of the Department of
11 Financial Services; amending ss. 322.143 and 655.968,
12 F.S.; correcting cross-references; providing an
13 effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Paragraphs (g) through (q) of subsection (1) of
18 section 655.005, Florida Statutes, are redesignated as
19 paragraphs (i) through (s), respectively, paragraphs (r) through
20 (y) are redesignated as paragraphs (u) through (bb),
21 respectively, paragraphs (z) and (aa) are redesignated as
22 paragraphs (t) and (g), respectively, and a new paragraph (h) is
23 added to that subsection to read:
24 655.005 Definitions.—
25 (1) As used in the financial institutions codes, unless
26 the context otherwise requires, the term:

27 (h) "Department" means the Department of Financial
28 Services.
29 Section 2. Section 655.0201, Florida Statutes, is amended
30 to read:
31 655.0201 Service of process~~, notice, or demand~~ on
32 financial institutions.—
33 ~~(1) Process against any financial institution authorized~~
34 ~~by federal or state law to transact business in this state may~~
35 ~~be served in accordance with chapter 48, chapter 49, chapter~~
36 ~~605, or part I of chapter 607, as appropriate.~~
37 (1)~~(2)~~ A ~~Any~~ financial institution authorized by federal
38 or state law to transact business in this state may designate a
39 place or registered agent within the state as the financial
40 institution's central location ~~agent~~ for service of process.
41 After a financial institution designates a place or registered
42 agent, such place or registered agent is the sole location for
43 service of process on the financial institution and all of its
44 branches within the state~~, notice, or demand required or~~
45 ~~permitted by law to be served on the financial institution. If~~
46 ~~the financial institution has no registered agent, or its~~
47 ~~registered agent cannot with reasonable diligence be served,~~
48 ~~service may be made to any executive officer of the financial~~
49 ~~institution at its principal place of business in this state~~.
50 (2)(a) To establish a central location for service of
51 process, a financial institution shall file notice designating
52 its central location with the department. The filing must

53 contain the central location's:
54 1. Addressee name.
55 2. Physical address.
56 3. Telephone number.
57 4. Business hours during which service will be accepted.
58 (b) The central location is the proper venue for service
59 of process for all types of service of process made on a
60 financial institution, including service for actions related to
61 garnishment, levy, injunctions, lawsuits, and the attachment of
62 safety deposit boxes, in accordance with chapters 60, 76, and 77
63 and the Florida Rules of Civil Procedure.
64 (c) The department shall publish a list of all central
65 locations on its website. The department must update the list to
66 reflect revocations or modifications made by a financial
67 institution within 15 business days after receipt of such
68 revocation or modification. The department's website must
69 specify the date the list was last updated.
70 (3) If service cannot be made in accordance with
71 subsection (1) ~~(2)~~, service may be made to an ~~any~~ officer~~,~~
72 ~~director, or business agent~~ of the financial institution at its
73 principal place of business or at any other branch, office, or
74 place of business in the state.
75 ~~(4) This section does not prescribe the only means, or~~
76 ~~necessarily the required means, of serving notice or demand on a~~
77 ~~financial institution.~~
78 Section 3. Subsection (9) of section 322.143, Florida

79 Statutes, is amended to read:
80 322.143 Use of a driver license or identification card.—
81 (9) This section does not apply to a financial institution
82 as defined in s. 655.005(1) ~~655.005(1)(i)~~.
83 Section 4. Paragraph (b) of subsection (1) of section
84 655.968, Florida Statutes, is amended to read:
85 655.968 Financial institutions; transactions relating to
86 Iran or terrorism.—
87 (1) As used in this section, the term:
88 (b) "Financial institution" has the same meaning as
89 defined in s. 655.005(1) ~~655.005(1)(i)~~.
90 Section 5. This act shall take effect July 1, 2016.

INSURANCE & BANKING SUBCOMMITTEE

HB 897 by Rep. Stone
Service of Process on Financial Institutions

AMENDMENT SUMMARY
February 1, 2016

Amendment 1 by Rep. Stone (strike-all): Retains current s. 655.0201, F.S., with the following changes:

- Requires, instead of permits, a financial institution to designate a registered agent as its agent for service of process, notice, or demand;
- Deletes language allowing service of process to be made on any executive officer of the financial institution at its principal place of business in Florida, if the financial institution has no registered agent or its registered agent cannot be served with reasonable diligence;
- Removes business agents and the financial institution's other branches, offices, or places of business in Florida as authorized recipients and locations at which service of process may be made on a financial institution, if service cannot be made on the registered agent; and
- Provides that this statute provides the only means of serving notice or demand on a financial institution, subject to chapters 48, 49, 605, or part I of chapter 607.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Stone offered the following:
4
5 **Amendment 1 (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Section 655.0201, Florida Statutes, is amended
8 to read:
9 655.0201 Service of process, notice, or demand on
10 financial institutions.—
11 (1) Process against any financial institution authorized
12 by federal or state law to transact business in this state may
13 be served in accordance with chapter 48, chapter 49, chapter
14 605, or part I of chapter 607, as appropriate.
15 (2) Any financial institution authorized by federal or
16 state law to transact business in this state shall ~~may~~ designate
17 a registered agent as the financial institution's agent for

18 service of process, notice, or demand required or permitted by
19 law to be served on the financial institution. ~~If the financial~~
20 ~~institution has no registered agent, or its registered agent~~
21 ~~cannot with reasonable diligence be served, service may be made~~
22 ~~to any executive officer of the financial institution at its~~
23 ~~principal place of business in this state.~~
24 (3) If service cannot be made in accordance with
25 subsection (2), service may be made to any officer~~,~~ or director,
26 ~~or business agent~~ of the financial institution at its principal
27 place of business ~~or at any other branch, office, or place of~~
28 ~~business in the state~~.
29 (4) Subject to the provisions of chapter 48, 49, chapter
30 605, or part 1 of chapter 607, this section ~~does not~~ prescribes
31 the only means~~, or necessarily the required means,~~ of serving
32 notice or demand on a financial institution.
33
34 ----------
35 **T I T L E A M E N D M E N T**
36 Remove everything before the enacting clause and insert:
37 An act relating to service of process on financial institutions;
38 amending s. 655.0201, F.S., revising requirements relating to
39 service of process on financial institutions authorized by
40 federal or state law to transact business in this this state;
41 providing an effective date.

HB 951

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 951 Health Plan Regulatory Administration
SPONSOR(S): Cummings
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1170

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Peterson KP	Luczynski
2) Appropriations Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.

The federal Patient Protection and Affordable Care Act (PPACA) has made significant changes to the U.S. health care system. 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, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements on individual and group coverage. In adopting PPACA Congress expressed that the federal law preempts state law only to the extent that it prevents the application of a provision of PPACA. PPACA effectively allows states to adopt and enforce laws that do not directly conflict with PPACA, but preempts any state law that does. Thus, provisions in Florida law that are in conflict with PPACA are preempted; whereas provisions that merely duplicate PPACA continue to be viable and enforceable by the OIR.

The adoption of PPACA has resulted in regulatory requirements that are sometimes conflicting or duplicative of Florida law. The bill makes numerous changes throughout the statutes repealing and, in some cases, revising state law requirements to reflect current federal law. Specifically, the bill deletes references to preexisting conditions and removes cross-references and other provisions of law related to their use; removes the guaranteed renewal requirements for individual HMO major medical policies; repeals the medical loss ratio standard for major medical health insurance policies; and repeals the requirement for certain insurers to provide an outline of coverage. In addition, the bill contains numerous sections that revise cross-references and transfer language that is required to continue implementation of requirements unrelated to those that have been repealed.

Finally, the bill repeals the requirement for health insurers to offer their insureds the right to convert coverage under a health insurance policy so as to have guaranteed access to health insurance when an insured loses his or her eligibility under his or her own policy.

This bill does not appear to have a fiscal impact on state or local government.

The bill provides for an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

State Regulation of Insurance

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.[1]

Federal Patient Protection and Affordable Care Act (PPACA)

The federal Patient Protection and Affordable Care Act was signed into law on March 23, 2010.[2] 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. 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, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements on individual and group coverage.[3]

Many of the changes outlined in PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[4] For example, PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):[5]

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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[1] s. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).

[2] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148. On March 30, 2010, PPACA was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. .No. 111-152

[3] 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.

[4] 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. Grandfathered health plan coverage is tied to the individual 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. *See* PPACA s§ 1251; 42 U.S.C. § 18011.

[5] PPACA § 1302; 42 U.S.C. § 300gg-6.

Under the U.S. Constitution's Supremacy Clause, a federal law may preempt state law.[6] Preemption occurs when Congress intentionally enacts legislation that is intended to supersede state law on the same subject.[7] In adopting PPACA Congress expressed that the federal law preempts state law only to the extent that it prevents the application of a provision of PPACA.[8] Specifically, PPACA states:

> *No Interference With State Regulatory Authority – Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.*[9]

Though expressed in the negative, PPACA preempts any state law that prevents the application of a provision of PPACA. PPACA effectively allows states to adopt and enforce laws that do not directly conflict with PPACA, but preempts any state law that does.[10] Thus, provisions in Florida law that are in conflict with PPACA are preempted; whereas provisions that merely duplicate PPACA continue to be viable and enforceable by the OIR.

Effect of the Bill

The adoption of PPACA has resulted in regulatory requirements that are sometimes conflicting or duplicative of Florida law. Some state law provisions were originally enacted in the 1990s to conform Florida law with HIPAA and have not been updated to reflect changes resulting from the adoption of PPACA. The bill makes numerous changes throughout the statutes repealing and, in some cases, revising state law requirements to reflect current federal law.

Preexisting Conditions

As a result of the enactment of PPACA, health insurers no longer can deny coverage or impose higher costs for individuals who have a preexisting condition. Sections 627.6561 and 641.31071, F.S., currently govern how preexisting conditions may be used by health insurers in determining how to write coverage.

- The bill deletes ss. 627.6561 and 641.31071, F.S., relating to preexisting conditions, and removes cross-references and other provisions of law related to their use.

Excepted Benefits and Creditable Coverage

Generally, health insurance is divided into two types of coverage: major medical coverage and excepted benefits. 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, and others. The concept of excepted benefits was introduced in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which imposed many requirements on health insurance unless that insurance was considered an excepted benefit. Florida adopted many of these requirements and modeled its statutory language on HIPAA, which is codified, in part, in s. 627.6561, F.S. PPACA does not directly regulate these excepted benefits.

- As described above, the bill repeals s. 627.6561, F.S., thereby repealing requirements related to preexisting conditions which are now obsolete because of PPACA. However, this section also defines creditable coverage—coverage deemed similar to traditional health insurance—for

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[6] U.S. Const. art. VI, cl. 2.
[7] *West Florida Regional Medical Center v. See*, 79 So.3d 1, 15 (Fla. 2012).
[8] PPACA § 1321(d); 42 U.S.C. § 18041(d).
[9] *Id.*
[10] National Association of Insurance Commissioners, *"Preemption and State Flexibility in PPACA" available at* http://www.naic.org/documents/index_health_reform_general_preemption_and_state_flex_ppaca.pdf (last visited Jan. 26, 2016).

purposes of implementing the preexisting condition requirements and lists excepted benefits—benefits deemed unlike traditional health insurance and, thus, not creditable. Cross-references to the listing of excepted benefits appear throughout Florida law for use in contexts unrelated to preexisting conditions. To preserve the concept of excepted benefits, as required elsewhere in statute, the bill transfers the listing to s. 627.6513, F.S., and conforms the many cross-references, accordingly. The bill does not change what are included as excepted benefits, only the location in statute where they appear.

- The bill treats creditable coverage similarly. By repealing s. 627.6561, F.S., the bill deletes the definition of "creditable coverage." The definition is needed, however, to implement other provisions of Florida law. As such, the bill transfers the definition in its entirety to s. 627.6562(3)(a), F.S., which defines "creditable coverage" for purposes of dependent coverage. The bill then conforms cross-references elsewhere in the statutes where the definition is still needed.

Guaranteed Availability and Renewability of Coverage

Individual major medical health maintenance organization (HMO) coverage is guaranteed issue and renewable. That is, PPACA requires health insurers to accept every individual and every employer who applies for coverage, commonly referred to as offering coverage on a guaranteed issue basis. PPACA also requires health insurers to renew or continue coverage in force subject only to certain exceptions.[11] Currently, Florida law also contains a guaranteed issue requirement applicable to individual coverage that includes insurance policies and HMO contracts.[12] In general, an insurer may not cancel coverage, except under limited circumstances specified in law.

- The bill amends s. 627.6425, F.S., to remove the guaranteed renewal requirements for individual HMO major medical policies.

Medical Loss Ratio; Payment of Rebates

Effective for plan years beginning January 1, 2011, 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.[13] 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.[14] Rebates are not required if the MLR is not met. The calculation of Florida's MLR is not consistent with federal regulations.

- The bill repeals s. 627.411(3), F. S., which sets forth the MLR standard for major medical health insurance policies, thereby eliminating the conflict with PPACA.

Outline of Coverage

Effective September 23, 2012, rules implementing PPACA required group health plans and health insurers to provide each participant or enrollee with a written summary that accurately describes the plan's benefits and coverage and that complies with the detailed requirements stated in the regulations.[15] The agencies' guidance includes a template, sample language, and a glossary of terms commonly used in connection with health insurance coverage. Section 627.642, F.S., requires an outline of coverage be provided to all individual policyholders and specifies requirements for its

[11] 45 C.F.R. § 147.104 and 45 C.F.R. § 147.106.
[12] s. 627.6425(1), F.S.
[13] 45 C.F.R. part 158.
[14] s. 627.411(3)(a), F.S.
[15] 26 CFR § 54.9815-2715(a)(1).

contents. While the intent of both requirements is to assist policyholders in understanding their contracts, it has been reported that the duplication instead has resulted in confusion.

- The bill repeals s. 627.642, F.S., which establishes the requirement for an outline of coverage.

Conversion Policies or Contracts

HIPAA requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to individuals who previously were covered for at least 18 months and meet other requirements. In 1997, Florida enacted legislation to conform state law to HIPAA.[16] In order to be eligible for guaranteed-issuance of individual coverage under HIPAA and Florida's conforming legislation, an individual must have prior creditable coverage for at least 18 months without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare, or Medicaid. Florida law provides two methods for guaranteeing access to individual coverage to individuals who lose their eligibility for prior coverage. One method requires the insurer or HMO that issued the group plan to offer an individual conversion policy to a person who loses eligibility for group coverage.[17] The other method for guaranteeing access to individual coverage is to allow an eligible person to purchase an individual policy from any insurer or HMO issuing individual coverage in the state.

In 2013, the Legislature passed legislation that eliminated statutory conversion rights when a person is covered for similar benefits by another insurance policy or is eligible for similar benefits, whether or not actually provided.[18] It has been argued that the PPACA eliminated the need for conversion policies because health insurance issuers are no longer able to deny those who apply for coverage based on preexisting conditions or health concerns. However, the OIR has interpreted the legislation as not eliminating statutory conversion rights with respect to HMO products. The OIR has opined that insurance products do not qualify as "similar like coverage in the case of an individual losing HMO coverage where another HMO product was not available."

- The bill repeals ss. 627.646, 627.6675, 641.3921, and 641.3922, F.S., related to conversion policies, and various provisions throughout Florida law related to their use.

B. SECTION DIRECTORY:

Section 1: amends s. 408.909, F.S., relating to flex plans, to conform a cross-reference.
Section 2: amends s. 409.817, F.S., relating to approval of health benefits coverage, to eliminate an exception to the prohibition on preexisting condition exclusions.
Section 3: amends s. 624.123, F.S., relating to certain international health insurance policies, to conform a cross-reference.
Section 4: amends s. 627.402, F.S., relating to definitions, to conform a cross-reference.
Section 5: amends s. 627.411, F.S., relating to grounds for disapproval, to remove the MLR requirements and the definition of incurred claims.
Section 6: repeals s. 627.6011, F.S., relating to mandated coverages.
Section 7: amends s. 627.602, F.S., relating to scope, format of policy, to conform a cross-reference.
Section 8: repeals s. 627.642, F.S. relating to outline of coverage.
Section 9: amends s. 627.6425, F.S., relating to renewability of individual coverage, to conform cross-references.
Section 10: repeals s. 627.646, F.S., relating to conversion on termination of eligibility.
Section 11: amends s. 627.6486, F.S., to conform a cross-reference.
Section 12: amends s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals, to conform cross-references and to eliminate a reference to conversion policies.

[16] Ch. 97-179, Laws of Fla.
[17] s. 627.6675, F.S. (applicable to group insurance policies) and s. 641.3921, F.S. (applicable to group HMO contracts).
[18] Ch. 2013-101, Laws of Fla.

Section 13: repeals s. 627.64871, F.S., relating to certification of coverage, to conform to the repeal of the preexisting condition provisions.
Section 14: amends s. 627.6488, F.S., relating to Florida Comprehensive Health Association, to conform cross-references.
Section 15: amends s. 627.6498, F.S., relating to minimum benefits coverage, to conform to the repeal of conversion policies.
Section 16: amends s. 627.6512, F.S., to conform cross-references.
Section 17: amends s. 627.6513, F.S., to reinstate the list of excepted coverages, which is transferred from s. 627.6561, F.S.
Section 18: amends s. 627.6515, F.S., relating to out-of-state groups, to conform a cross-reference.
Section 19: repeals s. 627.6561, F.S., relating to preexisting conditions.
Section 20: amends s. 627.6562, F.S., relating to dependent coverage, to reinstate the list of excepted coverages, which is transferred from s. 627.6561, F.S., for purposes of the definition of "creditable coverage" for dependent eligibility.
Section 21: amends s. 627.65626, F.S., relating to insurance rebates for healthy lifestyles, to conform a cross-reference.
Section 22: repeals s. 627.6675, F.S., relating to conversion on termination.
Section 23: amends s. 627.6699, F.S., relating to Employee Health Care Access Act, to conform cross-references and to remove provisions relating to preexisting conditions.
Section 24: amends s. 627.6741, F.S., relating to issuance, cancellation, nonrenewal, and replacement, to conform cross-references.
Section 25: amends s. 641.185, F.S., relating to health maintenance organization subscriber protections, to conform cross-references and to remove provisions relating to conversion policies.
Section 26: amends s. 641.31, F.S., relating to health maintenance contracts, to repeal the exemption from laws restricting subscriber cost-sharing.
Section 27: repeals s. 641.31071, F.S., relating to preexisting conditions.
Section 28: amends s. 641.3111, F.S., relating to extension of benefits, to remove a provision related to conversion.
Section 29: amends s. 641.312, F.S., related to scope, to conform a cross-reference.
Section 30: repeals ss. 641.3921 and 641.3922, F.S., relating to conversion.
Section 31: provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to the OIR, the right to convert coverage continues to be a significant and important benefit for some insureds. Maintenance of a statutory right to conversion is still necessary to ensure that

individuals do not have a lapse in coverage after leaving employment or losing eligibility under their own policy.[19]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Section 6 repeals Section 627.6011, F.S., which exempts excepted benefits from the requirement to provide mandatory health benefits. Because excepted benefits continue to exist in statute and are only relocated by the bill, this section should be restored and the cross-reference conformed to changes elsewhere in the bill.

Section 8 repeals the requirement that insurers provide an outline of coverage for individual or family accident and health insurance policies. PPACA requires a summary of benefits be included in individual and small group major medical policies. By repealing the state law provision, excepted benefit health insurance policies and large group certificate holders would no longer receive an outline of coverage under state law, and would not receive a summary of benefits under federal law.

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

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[19] Florida Office of Insurance Regulation, Agency Analysis of 2016 House Bill 951, p. 6 (Jan. 13, 2016).

1 A bill to be entitled
2 An act relating to health plan regulatory
3 administration; amending s. 408.909, F.S.; revising
4 the term "health care coverage" or "health flex plan
5 coverage"; amending s. 409.817, F.S.; deleting a
6 provision authorizing group insurance plans to impose
7 a certain preexisting condition exclusion; amending s.
8 624.123, F.S.; conforming a cross-reference; amending
9 s. 627.402, F.S.; revising the term "nongrandfathered
10 health plan"; amending s. 627.411, F.S.; deleting a
11 provision relating to a minimum loss ratio standard
12 for specified health insurance coverage; deleting
13 provisions specifying certain incurred claims;
14 repealing s. 627.6011, F.S., relating to mandated
15 coverages; amending s. 627.602, F.S.; revising
16 applicability; repealing s. 627.642, F.S., relating to
17 outline of coverage; amending s. 627.6425, F.S.;
18 revising the term "individual health insurance";
19 revising applicability; repealing s. 627.646, F.S.,
20 relating to conversion on termination of eligibility;
21 amending s. 627.6486, F.S.; conforming a cross-
22 reference; amending s. 627.6487, F.S.; revising
23 definitions; repealing s. 627.64871, F.S., relating to
24 certification of coverage; amending s. 627.6488, F.S.;
25 conforming a cross-reference; amending s. 627.6498,
26 F.S.; deleting a requirement that the Office of

27 Insurance Regulation establish certain standard risk
28 rates for coverages issued by the Florida
29 Comprehensive Health Association; amending s.
30 627.6512, F.S.; providing that certain group health
31 insurance policies are exempt from specified
32 requirements with respect to excepted benefits;
33 amending s. 627.6513, F.S.; specifying certain types
34 of benefits or coverages that are exempt; amending s.
35 627.6515, F.S.; conforming a cross-reference; deleting
36 a provision relating to a member's entitlement to
37 certain rights and options after providing a specified
38 notice of termination to an insurer; conforming a
39 provision to changes made by the act; repealing s.
40 627.6561, F.S., relating to preexisting conditions;
41 amending s. 627.6562, F.S.; redefining the term
42 "creditable coverage"; providing exceptions and
43 applicability; amending s. 627.65626, F.S.; conforming
44 a cross-reference; repealing s. 627.6675, F.S.,
45 relating to conversion on termination of eligibility;
46 amending s. 627.6699, F.S.; redefining terms; removing
47 a provision that requires a certain health benefit
48 plan to comply with specified preexisting condition
49 provisions; conforming a provision to changes made by
50 the act; amending s. 627.6741, F.S.; conforming a
51 provision to changes made by the act; conforming
52 cross-references; amending s. 641.185, F.S.; revising

53 certain standards to remove requirements for a health
54 maintenance organization to provide specified coverage
55 for preexisting conditions, provide specified
56 conversation on termination of eligibility, and
57 provide for specified conversion contracts and
58 conditions; conforming provisions to changes made by
59 the act; amending s. 641.31, F.S.; deleting a
60 provision specifying that a law restricting or
61 limiting deductibles, coinsurance, copayments, or
62 annual or lifetime maximum payments shall not apply to
63 a certain health maintenance organization contract;
64 conforming a cross-reference; repealing s. 641.31071,
65 F.S., relating to preexisting conditions; amending s.
66 641.3111, F.S.; deleting a provision specifying that a
67 subscriber is not entitled to an extension of benefits
68 under certain circumstances after termination of a
69 group health maintenance contract; amending s.
70 641.312, F.S.; conforming a cross-reference; repealing
71 ss. 641.3921 and 641.3922, F.S., relating to
72 conversion on termination of eligibility and
73 conversion contracts and conditions, respectively;
74 providing an effective date.
75
76 Be It Enacted by the Legislature of the State of Florida:
77
78 Section 1. Paragraph (d) of subsection (2) of section

79 408.909, Florida Statutes, is amended to read:
80 408.909 Health flex plans.—
81 (2) DEFINITIONS.—As used in this section, the term:
82 (d) "Health care coverage" or "health flex plan coverage"
83 means health care services that are covered as benefits under an
84 approved health flex plan or that are otherwise provided, either
85 directly or through arrangements with other persons, via a
86 health flex plan on a prepaid per capita basis or on a prepaid
87 aggregate fixed-sum basis. The terms may also include one or
88 more of the excepted benefits under s. 627.6513(1)-(13)
89 ~~627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered~~
90 ~~separately, or the benefits under s. 627.6561(5)(d), if offered~~
91 ~~as independent, noncoordinated benefits~~.
92 Section 2. Section 409.817, Florida Statutes, is amended
93 to read:
94 409.817 Approval of health benefits coverage; financial
95 assistance.—In order for health insurance coverage to qualify
96 for premium assistance payments for an eligible child under ss.
97 409.810-409.821, the health benefits coverage must:
98 (1) Be certified by the Office of Insurance Regulation of
99 the Financial Services Commission under s. 409.818 as meeting,
100 exceeding, or being actuarially equivalent to the benchmark
101 benefit plan;
102 (2) Be guarantee issued;
103 (3) Be community rated;
104 (4) Not impose any preexisting condition exclusion for

105 covered benefits; ~~however, group health insurance plans may~~
106 ~~permit the imposition of a preexisting condition exclusion, but~~
107 ~~only insofar as it is permitted under s. 627.6561;~~
108 (5) Comply with the applicable limitations on premiums and
109 cost sharing in s. 409.816;
110 (6) Comply with the quality assurance and access standards
111 developed under s. 409.820; and
112 (7) Establish periodic open enrollment periods, which may
113 not occur more frequently than quarterly.
114 Section 3. Paragraph (b) of subsection (1) of section
115 624.123, Florida Statutes, is amended to read:
116 624.123 Certain international health insurance policies;
117 exemption from code.—
118 (1) International health insurance policies and
119 applications may be solicited and sold in this state at any
120 international airport to a resident of a foreign country. Such
121 international health insurance policies shall be solicited and
122 sold only by a licensed health insurance agent and underwritten
123 only by an admitted insurer. For purposes of this subsection:
124 (b) "International health insurance policy" means health
125 insurance, as defined in s. 627.6562(3)(a)2. ~~627.6561(5)(a)2.~~,
126 which is offered to an individual, covering only a resident of a
127 foreign country on an annual basis.
128 Section 4. Subsection (2) of section 627.402, Florida
129 Statutes, is amended to read:
130 627.402 Definitions.—As used in this part, the term:

131 (2) "Nongrandfathered health plan" is a health insurance
132 policy or health maintenance organization contract that is not a
133 grandfathered health plan and does not provide the benefits or
134 coverages specified under s. 627.6513(1)-(14) ~~627.6561(5)(b)-~~
135 ~~(e)~~.
136 Section 5. Subsection (3) of section 627.411, Florida
137 Statutes, is amended to read:
138 627.411 Grounds for disapproval.—
139 ~~(3)(a) For health insurance coverage as described in s.~~
140 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~
141 ~~claims to earned premium for the form shall be 65 percent.~~
142 ~~(b) Incurred claims are claims occurring within a fixed~~
143 ~~period, whether or not paid during the same period, under the~~
144 ~~terms of the policy period.~~
145 ~~1. Claims include scheduled benefit payments or services~~
146 ~~provided by a provider or through a provider network for dental,~~
147 ~~vision, disability, and similar health benefits.~~
148 ~~2. Claims do not include state assessments, taxes, company~~
149 ~~expenses, or any expense incurred by the company for the cost of~~
150 ~~adjusting and settling a claim, including the review,~~
151 ~~qualification, oversight, management, or monitoring of a claim~~
152 ~~or incentives or compensation to providers for other than the~~
153 ~~provisions of health care services.~~
154 ~~3. A company may at its discretion include costs that are~~
155 ~~demonstrated to reduce claims, such as fraud intervention~~
156 ~~programs or case management costs, which are identified in each~~

157 ~~filing, are demonstrated to reduce claims costs, and do not~~
158 ~~result in increasing the experience period loss ratio by more~~
159 ~~than 5 percent.~~
160 ~~4. For scheduled claim payments, such as disability income~~
161 ~~or long-term care, the incurred claims shall be the present~~
162 ~~value of the benefit payments discounted for continuance and~~
163 ~~interest.~~
164 Section 6. Section 627.6011, Florida Statutes, is
165 repealed.
166 Section 7. Paragraph (h) of subsection (1) of section
167 627.602, Florida Statutes, is amended to read:
168 627.602 Scope, format of policy.—
169 (1) Each health insurance policy delivered or issued for
170 delivery to any person in this state must comply with all
171 applicable provisions of this code and all of the following
172 requirements:
173 (h) Section 641.312 and the provisions of the Employee
174 Retirement Income Security Act of 1974, as implemented by 29
175 C.F.R. s. 2560.503-1, relating to internal grievances. This
176 paragraph does not apply to a health insurance policy that is
177 subject to the Subscriber Assistance Program under s. 408.7056
178 or to the types of benefits or coverages provided under s.
179 627.6513(1)-(14) ~~627.6561(5)(b)-(e)~~ issued in any market.
180 Section 8. Section 627.642, Florida Statutes, is repealed.
181 Section 9. Subsections (1), (6), and (7) of section
182 627.6425, Florida Statutes, are amended to read:

183 627.6425 Renewability of individual coverage.—
184 (1) Except as otherwise provided in this section, an
185 insurer that provides individual health insurance coverage to an
186 individual shall renew or continue in force such coverage at the
187 option of the individual. For the purpose of this section, the
188 term "individual health insurance" means health insurance
189 coverage, as described in s. 624.603 ~~627.6561(5)(a)2.~~, offered
190 to an individual in this state, including certificates of
191 coverage offered to individuals in this state as part of a group
192 policy issued to an association outside this state, but the term
193 does not include short-term limited duration insurance or
194 excepted benefits specified in s. 627.6513(1)-(14) ~~subsection~~
195 ~~(6) or subsection (7)~~.
196 ~~(6) The requirements of this section do not apply to any~~
197 ~~health insurance coverage in relation to its provision of~~
198 ~~excepted benefits described in s. 627.6561(5)(b).~~
199 ~~(7) The requirements of this section do not apply to any~~
200 ~~health insurance coverage in relation to its provision of~~
201 ~~excepted benefits described in s. 627.6561(5)(c), (d), or (e),~~
202 ~~if the benefits are provided under a separate policy,~~
203 ~~certificate, or contract of insurance.~~
204 Section 10. Section 627.646, Florida Statutes, is
205 repealed.
206 Section 11. Paragraph (h) of subsection (2) of section
207 627.6486, Florida Statutes, is amended to read:
208 627.6486 Eligibility.—

209 (2)
210 (h) All eligible persons who are classified as high-risk
211 individuals pursuant to s. 627.6498(4)(a)3. ~~627.6498(4)(a)4.~~
212 shall, upon application or renewal, agree to be placed in a case
213 management system when it is determined by the board and the
214 plan case manager that such system will be cost-effective and
215 provide quality care to the individual.
216 Section 12. Paragraph (b) of subsection (2) and subsection
217 (3) of section 627.6487, Florida Statutes, are amended to read:
218 627.6487 Guaranteed availability of individual health
219 insurance coverage to eligible individuals.—
220 (2) For the purposes of this section:
221 (b) "Individual health insurance" means health insurance,
222 as defined in s. 624.603 ~~627.6561(5)(a)2.~~, which is offered to
223 an individual, including certificates of coverage offered to
224 individuals in this state as part of a group policy issued to an
225 association outside this state, but the term does not include
226 short-term limited duration insurance or excepted benefits
227 specified in s. 627.6513(1)-(14) ~~627.6561(5)(b) or, if the~~
228 ~~benefits are provided under a separate policy, certificate, or~~
229 ~~contract, the term does not include excepted benefits specified~~
230 ~~in s. 627.6561(5)(c), (d), or (e)~~.
231 (3) For the purposes of this section, the term "eligible
232 individual" means an individual:
233 (a)1. For whom, as of the date on which the individual
234 seeks coverage under this section, the aggregate of the periods

235 of creditable coverage, as defined in s. 627.6562(3) ~~627.6561(5)~~
236 ~~and (6)~~, is 18 or more months; and
237 2.a. Whose most recent prior creditable coverage was under
238 a group health plan, governmental plan, or church plan, or
239 health insurance coverage offered in connection with any such
240 plan; or
241 b. Whose most recent prior creditable coverage was under
242 an individual plan issued in this state by a health insurer or
243 health maintenance organization, which coverage is terminated
244 due to the insurer or health maintenance organization becoming
245 insolvent or discontinuing the offering of all individual
246 coverage in the State of Florida, or due to the insured no
247 longer living in the service area in the State of Florida of the
248 insurer or health maintenance organization that provides
249 coverage through a network plan in the State of Florida;
250 (b) Who is not eligible for coverage under:
251 1. A group health plan, as defined in s. 2791 of the
252 Public Health Service Act;
253 ~~2. A conversion policy or contract issued by an authorized~~
254 ~~insurer or health maintenance organization under s. 627.6675 or~~
255 ~~s. 641.3921, respectively, offered to an individual who is no~~
256 ~~longer eligible for coverage under either an insured or self-~~
257 ~~insured employer plan;~~
258 2.~~3.~~ Part A or part B of Title XVIII of the Social
259 Security Act; or
260 3.~~4.~~ A state plan under Title XIX of such act, or any

261 successor program, and does not have other health insurance
262 coverage;
263 (c) With respect to whom the most recent coverage within
264 the coverage period described in paragraph (a) was not
265 terminated based on a factor described in s. 627.6571(2)(a) or
266 (b), relating to nonpayment of premiums or fraud, unless such
267 nonpayment of premiums or fraud was due to acts of an employer
268 or person other than the individual;
269 (d) Who, having been offered the option of continuation
270 coverage under a COBRA continuation provision or under s.
271 627.6692, elected such coverage; and
272 (e) Who, if the individual elected such continuation
273 provision, has exhausted such continuation coverage under such
274 provision or program.
275 Section 13. Section 627.64871, Florida Statutes, is
276 repealed.
277 Section 14. Paragraph (h) of subsection (4) of section
278 627.6488, Florida Statutes, is amended to read:
279 627.6488 Florida Comprehensive Health Association.—
280 (4) The association shall:
281 (h) Contract with preferred provider organizations and
282 health maintenance organizations giving due consideration to the
283 preferred provider organizations and health maintenance
284 organizations which have contracted with the state group health
285 insurance program pursuant to s. 110.123. If cost-effective and
286 available in the county where the policyholder resides, the

287 board, upon application or renewal of a policy, shall place a
288 high-risk individual, as established under s. 627.6498(4)(a)3.
289 ~~627.6498(4)(a)4.~~, with the plan case manager who shall determine
290 the most cost-effective quality care system or health care
291 provider and shall place the individual in such system or with
292 such health care provider. If cost-effective and available in
293 the county where the policyholder resides, the board, with the
294 consent of the policyholder, may place a low-risk or medium-risk
295 individual, as established under s. 627.6498(4)(a)3.
296 ~~627.6498(4)(a)4.~~, with the plan case manager who may determine
297 the most cost-effective quality care system or health care
298 provider and shall place the individual in such system or with
299 such health care provider. Prior to and during the
300 implementation of case management, the plan case manager shall
301 obtain input from the policyholder, parent, or guardian.
302 Section 15. Paragraph (a) of subsection (4) of section
303 627.6498, Florida Statutes, is amended to read:
304 627.6498 Minimum benefits coverage; exclusions; premiums;
305 deductibles.—
306 (4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.—
307 (a) The plan shall provide for annual deductibles for
308 major medical expense coverage in the amount of $1,000 or any
309 higher amounts proposed by the board and approved by the office,
310 plus the benefits payable under any other type of insurance
311 coverage or workers' compensation. The schedule of premiums and
312 deductibles shall be established by the association. With regard

313 to any preferred provider arrangement utilized by the
314 association, the deductibles provided in this paragraph shall be
315 the minimum deductibles applicable to the preferred providers
316 and higher deductibles, as approved by the office, may be
317 applied to providers who are not preferred providers.
318 1. Separate schedules of premium rates based on age may
319 apply for individual risks.
320 2. Rates are subject to approval by the office.
321 ~~3. Standard risk rates for coverages issued by the~~
322 ~~association shall be established by the office, pursuant to s.~~
323 ~~627.6675(3).~~
324 3.~~4.~~ The board shall establish separate premium schedules
325 for low-risk individuals, medium-risk individuals, and high-risk
326 individuals and shall revise premium schedules annually
327 beginning January 1999. No rate shall exceed 200 percent of the
328 standard risk rate for low-risk individuals, 225 percent of the
329 standard risk rate for medium-risk individuals, or 250 percent
330 of the standard risk rate for high-risk individuals. For the
331 purpose of determining what constitutes a low-risk individual,
332 medium-risk individual, or high-risk individual, the board shall
333 consider the anticipated claims payment for individuals based
334 upon an individual's health condition.
335 Section 16. Section 627.6512, Florida Statutes, is amended
336 to read:
337 627.6512 Exemption of certain group health insurance
338 policies.—Sections ~~627.6561,~~ 627.65615, 627.65625, and 627.6571

339 do not apply to~~:~~
340 ~~(1)~~ any group insurance policy in relation to its
341 provision of excepted benefits~~:~~ described in s. 627.6513(1)-(14)
342 ~~627.6561(5)(b)~~.
343 ~~(2) Any group health insurance policy in relation to its~~
344 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~
345 ~~if the benefits:~~
346 ~~(a) Are provided under a separate policy, certificate, or~~
347 ~~contract of insurance; or~~
348 ~~(b) Are otherwise not an integral part of the policy.~~
349 ~~(3) Any group health insurance policy in relation to its~~
350 ~~provision of excepted benefits described in s. 627.6561(5)(d),~~
351 ~~if all of the following conditions are met:~~
352 ~~(a) The benefits are provided under a separate policy,~~
353 ~~certificate, or contract of insurance;~~
354 ~~(b) There is no coordination between the provision of such~~
355 ~~benefits and any exclusion of benefits under any group policy~~
356 ~~maintained by the same policyholder; and~~
357 ~~(c) Such benefits are paid with respect to an event~~
358 ~~without regard to whether benefits are provided with respect to~~
359 ~~such an event under any group health policy maintained by the~~
360 ~~same policyholder.~~
361 ~~(4) Any group health policy in relation to its provision~~
362 ~~of excepted benefits described in s. 627.6561(5)(e), if the~~
363 ~~benefits are provided under a separate policy, certificate, or~~
364 ~~contract of insurance.~~

365 Section 17. Section 627.6513, Florida Statutes, is amended
366 to read:
367 627.6513 Scope.—Section 641.312 and the provisions of the
368 Employee Retirement Income Security Act of 1974, as implemented
369 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
370 apply to all group health insurance policies issued under this
371 part. This section does not apply to a group health insurance
372 policy that is subject to the Subscriber Assistance Program in
373 s. 408.7056 or to: ~~the types of benefits or coverages provided~~
374 ~~under s. 627.6561(5)(b)-(e) issued in any market.~~
375 (1) Coverage only for accident, or disability income
376 insurance, or any combination thereof.
377 (2) Coverage issued as a supplement to liability
378 insurance.
379 (3) Liability insurance, including general liability
380 insurance and automobile liability insurance.
381 (4) Workers' compensation or similar insurance.
382 (5) Automobile medical payment insurance.
383 (6) Credit-only insurance.
384 (7) Coverage for onsite medical clinics, including prepaid
385 health clinics under part II of chapter 641.
386 (8) Other similar insurance coverage, specified in rules
387 adopted by the commission, under which benefits for medical care
388 are secondary or incidental to other insurance benefits. To the
389 extent possible, such rules must be consistent with regulations
390 adopted by the United States Department of Health and Human

391 Services.
392 (9) Limited scope dental or vision benefits.
393 (10) Benefits for long-term care, nursing home care, home
394 health care, community-based care, or any combination thereof.
395 (11) Other similar, limited benefits as specified in rules
396 adopted by the commission.
397 (12) Coverage only for a specified disease or illness, if
398 offered as independent, noncoordinated benefits.
399 (13) Hospital indemnity or other fixed indemnity
400 insurance, if offered as independent, noncoordinated benefits.
401 (14) Benefits provided through a Medicare supplemental
402 health insurance, as defined under s. 1882(g)(1) of the Social
403 Security Act, coverage supplemental to the coverage provided
404 under 10 U.S.C. chapter 55, and similar supplemental coverage
405 provided to coverage under a group health plan, which are
406 offered as a separate insurance policy and as independent,
407 noncoordinated benefits.
408 Section 18. Subsections (2) and (9) of section 627.6515,
409 Florida Statutes, are amended to read:
410 627.6515 Out-of-state groups.—
411 (2) Except as otherwise provided in this part, this part
412 does not apply to a group health insurance policy issued or
413 delivered outside this state under which a resident of this
414 state is provided coverage if:
415 (a) The policy is issued to an employee group the
416 composition of which is substantially as described in s.

417 627.653; a labor union group or association group the
418 composition of which is substantially as described in s.
419 627.654; an additional group the composition of which is
420 substantially as described in s. 627.656; a group insured under
421 a blanket health policy when the composition of the group is
422 substantially in compliance with s. 627.659; a group insured
423 under a franchise health policy when the composition of the
424 group is substantially in compliance with s. 627.663; an
425 association group to cover persons associated in any other
426 common group, which common group is formed primarily for
427 purposes other than providing insurance; a group that is
428 established primarily for the purpose of providing group
429 insurance, provided the benefits are reasonable in relation to
430 the premiums charged thereunder and the issuance of the group
431 policy has resulted, or will result, in economies of
432 administration; or a group of insurance agents of an insurer,
433 which insurer is the policyholder.~~;~~
434 (b) Certificates evidencing coverage under the policy are
435 issued to residents of this state and contain in contrasting
436 color and not less than 10-point type the following statement:
437 "The benefits of the policy providing your coverage are governed
438 primarily by the law of a state other than Florida."~~; and~~
439 (c) The policy provides the benefits specified in ss.
440 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121,
441 627.66122, 627.6613, 627.667, ~~627.6675,~~ 627.6691, and 627.66911,
442 and complies with the requirements of s. 627.66996.

443 (d) Applications for certificates of coverage offered to
444 residents of this state must contain, in contrasting color and
445 not less than 12-point type, the following statement on the same
446 page as the applicant's signature:
447
448 "This policy is primarily governed by the laws of
449 ...insert state where the master policy is filed....
450 As a result, all of the rating laws applicable to
451 policies filed in this state do not apply to this
452 coverage, which may result in increases in your
453 premium at renewal that would not be permissible under
454 a Florida-approved policy. Any purchase of individual
455 health insurance should be considered carefully, as
456 future medical conditions may make it impossible to
457 qualify for another individual health policy. For
458 information concerning individual health coverage
459 under a Florida-approved policy, consult your agent or
460 the Florida Department of Financial Services."
461
462 This paragraph applies only to group certificates providing
463 health insurance coverage which require individualized
464 underwriting to determine coverage eligibility for an individual
465 or premium rates to be charged to an individual except for the
466 following:
467 1. Policies issued to provide coverage to groups of
468 persons all of whom are in the same or functionally related

469 licensed professions, and providing coverage only to such
470 licensed professionals, their employees, or their dependents;
471 2. Policies providing coverage to small employers as
472 defined by s. 627.6699. Such policies shall be subject to, and
473 governed by, the provisions of s. 627.6699;
474 3. Policies issued to a bona fide association, as defined
475 by s. 627.6571(5), provided that there is a person or board
476 acting as a fiduciary for the benefit of the members, and such
477 association is not owned, controlled by, or otherwise associated
478 with the insurance company; or
479 4. Any accidental death, accidental death and
480 dismemberment, accident-only, vision-only, dental-only, hospital
481 indemnity-only, hospital accident-only, cancer, specified
482 disease, Medicare supplement, products that supplement Medicare,
483 long-term care, or disability income insurance, or similar
484 supplemental plans provided under a separate policy,
485 certificate, or contract of insurance, which cannot duplicate
486 coverage under an underlying health plan, coinsurance, or
487 deductibles or coverage issued as a supplement to workers'
488 compensation or similar insurance, or automobile medical-payment
489 insurance.
490 (9) Any insured shall be able to terminate membership or
491 affiliation with the group to whom the master policy is issued.
492 An insured that elects to terminate his or her membership or
493 affiliation with the group shall provide written notice to the
494 insurer. ~~Upon providing the written notice, the member shall be~~

495 ~~entitled to the rights and options provided by s. 627.6675.~~
496 Section 19. Section 627.6561, Florida Statutes, is
497 repealed.
498 Section 20. Subsection (3) of section 627.6562, Florida
499 Statutes, is amended to read:
500 627.6562 Dependent coverage.—
501 (3) If, pursuant to subsection (2), a child is provided
502 coverage under the parent's policy after the end of the calendar
503 year in which the child reaches age 25 and coverage for the
504 child is subsequently terminated, the child is not eligible to
505 be covered under the parent's policy unless the child was
506 continuously covered by other creditable coverage without a gap
507 in coverage of more than 63 days.
508 (a) For the purposes of this subsection, the term
509 "creditable coverage" means, with respect to an individual,
510 coverage of the individual under any of the following: ~~has the~~
511 ~~same meaning as provided in s. 627.6561(5).~~
512 1. A group health plan, as defined in s. 2791 of the
513 Public Health Service Act.
514 2. Health insurance coverage consisting of medical care
515 provided directly through insurance or reimbursement or
516 otherwise, and including terms and services paid for as medical
517 care, under any hospital or medical service policy or
518 certificate, hospital or medical service plan contract, or
519 health maintenance contract offered by a health insurance
520 issuer.

521 3. Part A or part B of Title XVIII of the Social Security
522 Act.
523 4. Title XIX of the Social Security Act, other than
524 coverage consisting solely of benefits under s. 1928.
525 5. 10 U.S.C. chapter 55.
526 6. A medical care program of the Indian Health Service or
527 of a tribal organization.
528 7. The Florida Comprehensive Health Association or another
529 state health benefit risk pool.
530 8. A health plan offered under 5 U.S.C. chapter 89.
531 9. A public health plan as defined by rules adopted by the
532 commission. To the greatest extent possible, such rules must be
533 consistent with regulations adopted by the United States
534 Department of Health and Human Services.
535 10. A health benefit plan under s. 5(e) of the Peace Corps
536 Act, 22 U.S.C. s. 2504(e).
537 (b) Creditable coverage does not include coverage that
538 consists of one or more, or any combination thereof, of the
539 following excepted benefits:
540 1. Coverage only for accident, or disability income
541 insurance, or any combination thereof.
542 2. Coverage issued as a supplement to liability insurance.
543 3. Liability insurance, including general liability
544 insurance and automobile liability insurance.
545 4. Workers' compensation or similar insurance.
546 5. Automobile medical payment insurance.

547 6. Credit-only insurance.
548 7. Coverage for onsite medical clinics, including prepaid
549 health clinics under part II of chapter 641.
550 8. Other similar insurance coverage specified in rules
551 adopted by the commission under which benefits for medical care
552 are secondary or incidental to other insurance benefits. To the
553 extent possible, such rules must be consistent with regulations
554 adopted by the United States Department of Health and Human
555 Services.
556 (c) The following benefits are not subject to the
557 creditable coverage requirements, if offered separately:
558 1. Limited scope dental or vision benefits.
559 2. Benefits for long-term care, nursing home care, home
560 health care, community-based care, or any combination thereof.
561 3. Other similar, limited benefits as are specified in
562 rules adopted by the commission.
563 (d) The following benefits are not subject to creditable
564 coverage requirements if offered as independent, noncoordinated
565 benefits:
566 1. Coverage only for a specified disease or illness.
567 2. Hospital indemnity or other fixed indemnity insurance.
568 (e) Benefits provided through a Medicare supplemental
569 health insurance, as defined under s. 1882(g)(1) of the Social
570 Security Act, coverage supplemental to the coverage provided
571 under 10 U.S.C. chapter 55, and similar supplemental coverage
572 provided to coverage under a group health plan are not

573 considered creditable coverage if offered as a separate
574 insurance policy.
575 Section 21. Subsection (1) of section 627.65626, Florida
576 Statutes, is amended to read:
577 627.65626 Insurance rebates for healthy lifestyles.—
578 (1) Any rate, rating schedule, or rating manual for a
579 health insurance policy that provides creditable coverage as
580 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office
581 shall provide for an appropriate rebate of premiums paid in the
582 last policy year, contract year, or calendar year when the
583 majority of members of a health plan have enrolled and
584 maintained participation in any health wellness, maintenance, or
585 improvement program offered by the group policyholder and health
586 plan. The rebate may be based upon premiums paid in the last
587 calendar year or policy year. The group must provide evidence of
588 demonstrative maintenance or improvement of the enrollees'
589 health status as determined by assessments of agreed-upon health
590 status indicators between the policyholder and the health
591 insurer, including, but not limited to, reduction in weight,
592 body mass index, and smoking cessation. The group or health
593 insurer may contract with a third-party administrator to
594 assemble and report the health status required in this
595 subsection between the policyholder and the health insurer. Any
596 rebate provided by the health insurer is presumed to be
597 appropriate unless credible data demonstrates otherwise, or
598 unless the rebate program requires the insured to incur costs to

599 qualify for the rebate which equal or exceed the value of the
600 rebate, but the rebate may not exceed 10 percent of paid
601 premiums.
602 Section 22. Section 627.6675, Florida Statutes, is
603 repealed.
604 Section 23. Paragraphs (e), (l), and (n) of subsection
605 (3), paragraphs (c) and (d) of subsection (5), and paragraph (b)
606 of subsection (6) of section 627.6699, Florida Statutes, are
607 amended to read:
608 627.6699 Employee Health Care Access Act.—
609 (3) DEFINITIONS.—As used in this section, the term:
610 (e) "Creditable coverage" has the same meaning ascribed in
611 s. 627.6562(3) ~~627.6561~~.
612 (l) "Late enrollee" means an eligible employee or
613 dependent who, with respect to coverage under a group health
614 policy, is a participant or beneficiary who enrolls under the
615 policy other than during:
616 1. The first period in which the individual is eligible to
617 enroll under the policy.
618 2. A special enrollment period, as provided under s.
619 627.65615 ~~as defined under s. 627.6561(1)(b)~~.
620 (n) "Modified community rating" means a method used to
621 develop carrier premiums which spreads financial risk across a
622 large population; allows the use of separate rating factors for
623 age, gender, family composition, tobacco usage, and geographic
624 area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows

625 adjustments for: claims experience, health status, or duration
626 of coverage as permitted under subparagraph (6)(b)5.; and
627 administrative and acquisition expenses as permitted under
628 subparagraph (6)(b)5.
629 (5) AVAILABILITY OF COVERAGE.—
630 ~~(c) Except as provided in paragraph (d), a health benefit~~
631 ~~plan covering small employers must comply with preexisting~~
632 ~~condition provisions specified in s. 627.6561 or, for health~~
633 ~~maintenance contracts, in s. 641.31071.~~
634 (c) ~~(d)~~ A health benefit plan covering small employers,
635 issued or renewed on or after January 1, 1994, must comply with
636 the following conditions:
637 1. All health benefit plans must be offered and issued on
638 a guaranteed-issue basis. Additional or increased benefits may
639 only be offered by riders.
640 ~~2. Paragraph (c) applies to health benefit plans issued to~~
641 ~~a small employer who has two or more eligible employees and to~~
642 ~~health benefit plans that are issued to a small employer who has~~
643 ~~fewer than two eligible employees and that cover an employee who~~
644 ~~has had creditable coverage continually to a date not more than~~
645 ~~63 days before the effective date of the new coverage.~~
646 2. ~~3.~~ For health benefit plans that are issued to a small
647 employer who has fewer than two employees and that cover an
648 employee who has not been continually covered by creditable
649 coverage within 63 days before the effective date of the new
650 coverage, preexisting condition provisions must not exclude

651 coverage for a period beyond 24 months following the employee's
652 effective date of coverage and may relate only to:
653 a. Conditions that, during the 24-month period immediately
654 preceding the effective date of coverage, had manifested
655 themselves in such a manner as would cause an ordinarily prudent
656 person to seek medical advice, diagnosis, care, or treatment or
657 for which medical advice, diagnosis, care, or treatment was
658 recommended or received; or
659 b. A pregnancy existing on the effective date of coverage.
660 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—
661 (b) For all small employer health benefit plans that are
662 subject to this section and issued by small employer carriers on
663 or after January 1, 1994, premium rates for health benefit plans
664 are subject to the following:
665 1. Small employer carriers must use a modified community
666 rating methodology in which the premium for each small employer
667 is determined solely on the basis of the eligible employee's and
668 eligible dependent's gender, age, family composition, tobacco
669 use, or geographic area as determined under paragraph (5)(e)
670 ~~(5)(f)~~ and in which the premium may be adjusted as permitted by
671 this paragraph. A small employer carrier is not required to use
672 gender as a rating factor for a nongrandfathered health plan.
673 2. Rating factors related to age, gender, family
674 composition, tobacco use, or geographic location may be
675 developed by each carrier to reflect the carrier's experience.
676 The factors used by carriers are subject to office review and

677 approval.
678 3. Small employer carriers may not modify the rate for a
679 small employer for 12 months from the initial issue date or
680 renewal date, unless the composition of the group changes or
681 benefits are changed. However, a small employer carrier may
682 modify the rate one time within the 12 months after the initial
683 issue date for a small employer who enrolls under a previously
684 issued group policy that has a common anniversary date for all
685 employers covered under the policy if:
686 a. The carrier discloses to the employer in a clear and
687 conspicuous manner the date of the first renewal and the fact
688 that the premium may increase on or after that date.
689 b. The insurer demonstrates to the office that
690 efficiencies in administration are achieved and reflected in the
691 rates charged to small employers covered under the policy.
692 4. A carrier may issue a group health insurance policy to
693 a small employer health alliance or other group association with
694 rates that reflect a premium credit for expense savings
695 attributable to administrative activities being performed by the
696 alliance or group association if such expense savings are
697 specifically documented in the insurer's rate filing and are
698 approved by the office. Any such credit may not be based on
699 different morbidity assumptions or on any other factor related
700 to the health status or claims experience of any person covered
701 under the policy. This subparagraph does not exempt an alliance
702 or group association from licensure for activities that require

703 licensure under the insurance code. A carrier issuing a group
704 health insurance policy to a small employer health alliance or
705 other group association shall allow any properly licensed and
706 appointed agent of that carrier to market and sell the small
707 employer health alliance or other group association policy. Such
708 agent shall be paid the usual and customary commission paid to
709 any agent selling the policy.
710 5. Any adjustments in rates for claims experience, health
711 status, or duration of coverage may not be charged to individual
712 employees or dependents. For a small employer's policy, such
713 adjustments may not result in a rate for the small employer
714 which deviates more than 15 percent from the carrier's approved
715 rate. Any such adjustment must be applied uniformly to the rates
716 charged for all employees and dependents of the small employer.
717 A small employer carrier may make an adjustment to a small
718 employer's renewal premium, up to 10 percent annually, due to
719 the claims experience, health status, or duration of coverage of
720 the employees or dependents of the small employer. If the
721 aggregate resulting from the application of such adjustment
722 exceeds the premium that would have been charged by application
723 of the approved modified community rate by 4 percent for the
724 current policy term, the carrier shall limit the application of
725 such adjustments only to minus adjustments. For any subsequent
726 policy term, if the total aggregate adjusted premium actually
727 charged does not exceed the premium that would have been charged
728 by application of the approved modified community rate by 4

729 percent, the carrier may apply both plus and minus adjustments.
730 A small employer carrier may provide a credit to a small
731 employer's premium based on administrative and acquisition
732 expense differences resulting from the size of the group. Group
733 size administrative and acquisition expense factors may be
734 developed by each carrier to reflect the carrier's experience
735 and are subject to office review and approval.
736 6. A small employer carrier rating methodology may include
737 separate rating categories for one dependent child, for two
738 dependent children, and for three or more dependent children for
739 family coverage of employees having a spouse and dependent
740 children or employees having dependent children only. A small
741 employer carrier may have fewer, but not greater, numbers of
742 categories for dependent children than those specified in this
743 subparagraph.
744 7. Small employer carriers may not use a composite rating
745 methodology to rate a small employer with fewer than 10
746 employees. For the purposes of this subparagraph, the term
747 "composite rating methodology" means a rating methodology that
748 averages the impact of the rating factors for age and gender in
749 the premiums charged to all of the employees of a small
750 employer.
751 8. A carrier may separate the experience of small employer
752 groups with fewer than 2 eligible employees from the experience
753 of small employer groups with 2-50 eligible employees for
754 purposes of determining an alternative modified community

755 rating.
756 a. If a carrier separates the experience of small employer
757 groups, the rate to be charged to small employer groups of fewer
758 than 2 eligible employees may not exceed 150 percent of the rate
759 determined for small employer groups of 2-50 eligible employees.
760 However, the carrier may charge excess losses of the experience
761 pool consisting of small employer groups with less than 2
762 eligible employees to the experience pool consisting of small
763 employer groups with 2-50 eligible employees so that all losses
764 are allocated and the 150-percent rate limit on the experience
765 pool consisting of small employer groups with less than 2
766 eligible employees is maintained.
767 b. Notwithstanding s. 627.411(1), the rate to be charged
768 to a small employer group of fewer than 2 eligible employees,
769 insured as of July 1, 2002, may be up to 125 percent of the rate
770 determined for small employer groups of 2-50 eligible employees
771 for the first annual renewal and 150 percent for subsequent
772 annual renewals.
773 9. A carrier shall separate the experience of
774 grandfathered health plans from nongrandfathered health plans
775 for determining rates.
776 Section 24. Subsection (1) and paragraph (c) of subsection
777 (2) of section 627.6741, Florida Statutes, are amended to read:
778 627.6741 Issuance, cancellation, nonrenewal, and
779 replacement.—
780 (1)(a) An insurer issuing Medicare supplement policies in

781 this state shall offer the opportunity of enrolling in a
782 Medicare supplement policy, without conditioning the issuance or
783 effectiveness of the policy on, and without discriminating in
784 the price of the policy based on, the medical or health status
785 or receipt of health care by the individual:
786 1. To any individual who is 65 years of age or older, or
787 under 65 years of age and eligible for Medicare by reason of
788 disability or end-stage renal disease, and who resides in this
789 state, upon the request of the individual during the 6-month
790 period beginning with the first month in which the individual
791 has attained 65 years of age and is enrolled in Medicare Part B,
792 or is eligible for Medicare by reason of a disability or end-
793 stage renal disease, and is enrolled in Medicare Part B; or
794 2. To any individual who is 65 years of age or older, or
795 under 65 years of age and eligible for Medicare by reason of a
796 disability or end-stage renal disease, who is enrolled in
797 Medicare Part B, and who resides in this state, upon the request
798 of the individual during the 2-month period following
799 termination of coverage under a group health insurance policy.
800 (b) The 6-month period to enroll in a Medicare supplement
801 policy for an individual who is under 65 years of age and is
802 eligible for Medicare by reason of disability or end-stage renal
803 disease and otherwise eligible under subparagraph (a)1. or
804 subparagraph (a)2. and first enrolled in Medicare Part B before
805 October 1, 2009, begins on October 1, 2009.
806 (c) A company that has offered Medicare supplement

807 policies to individuals under 65 years of age who are eligible
808 for Medicare by reason of disability or end-stage renal disease
809 before October 1, 2009, may, for one time only, effect a rate
810 schedule change that redefines the age bands of the premium
811 classes without activating the period of discontinuance required
812 by s. 627.410(6)(e)2.
813 (d) As a part of an insurer's rate filings, before and
814 including the insurer's first rate filing for a block of policy
815 forms in 2015, notwithstanding the provisions of s.
816 627.410(6)(e)3., an insurer shall consider the experience of the
817 policies or certificates for the premium classes including
818 individuals under 65 years of age and eligible for Medicare by
819 reason of disability or end-stage renal disease separately from
820 the balance of the block so as not to affect the other premium
821 classes. For filings in such time period only, credibility of
822 that experience shall be as follows: if a block of policy forms
823 has 1,250 or more policies or certificates in force in the age
824 band including ages under 65 years of age, full or 100-percent
825 credibility shall be given to the experience; and if fewer than
826 250 policies or certificates are in force, no or zero-percent
827 credibility shall be given. Linear interpolation shall be used
828 for in-force amounts between the low and high values. Florida-
829 only experience shall be used if it is 100-percent credible. If
830 Florida-only experience is not 100-percent credible, a
831 combination of Florida-only and nationwide experience shall be
832 used. If Florida-only experience is zero-percent credible,

833 nationwide experience shall be used. The insurer may file its
834 initial rates and any rate adjustment based upon the experience
835 of these policies or certificates or based upon expected claim
836 experience using experience data of the same company, other
837 companies in the same or other states, or using data publicly
838 available from the Centers for Medicaid and Medicare Services if
839 the insurer's combined Florida and nationwide experience is not
840 100-percent credible, separate from the balance of all other
841 Medicare supplement policies.
842
843 A Medicare supplement policy issued to an individual under
844 subparagraph (a)1. or subparagraph (a)2. may not exclude
845 benefits based on a preexisting condition if the individual has
846 a continuous period of creditable coverage, as defined in s.
847 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
848 application for coverage.
849 (2) For both individual and group Medicare supplement
850 policies:
851 (c) If a Medicare supplement policy or certificate
852 replaces another Medicare supplement policy or certificate or
853 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
854 the replacing insurer shall waive any time periods applicable to
855 preexisting conditions, waiting periods, elimination periods,
856 and probationary periods in the new Medicare supplement policy
857 for similar benefits to the extent such time was spent under the
858 original policy~~, subject to the requirements of s. 627.6561(6)~~

859 ~~(11)~~.
860 Section 25. Paragraphs (f) and (h) of subsection (1) of
861 section 641.185, Florida Statutes, are amended to read:
862 641.185 Health maintenance organization subscriber
863 protections.—
864 (1) With respect to the provisions of this part and part
865 III, the principles expressed in the following statements shall
866 serve as standards to be followed by the commission, the office,
867 the department, and the Agency for Health Care Administration in
868 exercising their powers and duties, in exercising administrative
869 discretion, in administrative interpretations of the law, in
870 enforcing its provisions, and in adopting rules:
871 (f) A health maintenance organization subscriber should
872 receive the flexibility to transfer to another Florida health
873 maintenance organization, regardless of health status, pursuant
874 to ss. 641.228, 641.3104, and ~~641.3107,~~ 641.3111~~, 641.3921, and~~
875 ~~641.3922~~.
876 (h) A health maintenance organization that issues a group
877 health contract must~~: provide coverage for preexisting~~
878 ~~conditions pursuant to s. 641.31071;~~ guarantee renewability of
879 coverage pursuant to s. 641.31074,~~;~~ provide notice of
880 cancellation pursuant to s. 641.3108, and~~;~~ provide extension of
881 benefits pursuant to s. 641.3111~~; provide for conversion on~~
882 ~~termination of eligibility pursuant to s. 641.3921; and provide~~
883 ~~for conversion contracts and conditions pursuant to s. 641.3922~~.
884 Section 26. Subsection (2) and paragraph (a) of subsection

885 (40) of section 641.31, Florida Statutes, are amended to read:
886 641.31 Health maintenance contracts.—
887 (2) The rates charged by any health maintenance
888 organization to its subscribers shall not be excessive,
889 inadequate, or unfairly discriminatory or follow a rating
890 methodology that is inconsistent, indeterminate, or ambiguous or
891 encourages misrepresentation or misunderstanding. ~~A law~~
892 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
893 ~~annual or lifetime maximum payments shall not apply to any~~
894 ~~health maintenance organization contract that provides coverage~~
895 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
896 ~~individual or a group of 51 or more persons.~~ The commission, in
897 accordance with generally accepted actuarial practice as applied
898 to health maintenance organizations, may define by rule what
899 constitutes excessive, inadequate, or unfairly discriminatory
900 rates and may require whatever information it deems necessary to
901 determine that a rate or proposed rate meets the requirements of
902 this subsection.
903 (40)(a) Any group rate, rating schedule, or rating manual
904 for a health maintenance organization policy, which provides
905 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
906 filed with the office shall provide for an appropriate rebate of
907 premiums paid in the last policy year, contract year, or
908 calendar year when the majority of members of a health plan are
909 enrolled in and have maintained participation in any health
910 wellness, maintenance, or improvement program offered by the

911 group contract holder. The group must provide evidence of
912 demonstrative maintenance or improvement of his or her health
913 status as determined by assessments of agreed-upon health status
914 indicators between the group and the health insurer, including,
915 but not limited to, reduction in weight, body mass index, and
916 smoking cessation. Any rebate provided by the health maintenance
917 organization is presumed to be appropriate unless credible data
918 demonstrates otherwise, or unless the rebate program requires
919 the insured to incur costs to qualify for the rebate which
920 equals or exceeds the value of the rebate but the rebate may not
921 exceed 10 percent of paid premiums.
922 Section 27. Section 641.31071, Florida Statutes, is
923 repealed.
924 Section 28. Subsection (4) of section 641.3111, Florida
925 Statutes, is amended to read:
926 641.3111 Extension of benefits.—
927 ~~(4) Except as provided in subsection (1), no subscriber is~~
928 ~~entitled to an extension of benefits if the termination of the~~
929 ~~contract by the health maintenance organization is based upon~~
930 ~~any event referred to in s. 641.3922(7)(a), (b), or (c).~~
931 Section 29. Section 641.312, Florida Statutes, is amended
932 to read:
933 641.312 Scope.—The Office of Insurance Regulation may
934 adopt rules to administer the provisions of the National
935 Association of Insurance Commissioners' Uniform Health Carrier
936 External Review Model Act, issued by the National Association of

937 Insurance Commissioners and dated April 2010. This section does
938 not apply to a health maintenance contract that is subject to
939 the Subscriber Assistance Program under s. 408.7056 or to the
940 types of benefits or coverages provided under s. 627.6513(1)-
941 (14) ~~627.6561(5)(b)-(e)~~ issued in any market.
942 Section 30. Sections 641.3921 and 641.3922, Florida
943 Statutes, are repealed.
944 Section 31. This act shall take effect July 1, 2016.

INSURANCE & BANKING SUBCOMMITTEE

HB 951 by Rep. Cummings
Health Plan Regulatory Administration

AMENDMENT SUMMARY
February 1, 2016

Amendment 1 by Rep. Cummings (Strike-all amendment):

- Restores all provisions related to conversion policies and makes technical and conforming changes, as needed.
- Restores the requirement for excepted benefit policies and large group certificate holders to provide policyholders an outline of coverage.
- Restores the guaranteed renewability requirements for individual HMO major medical policies.
- Removes sections related to the Florida Comprehensive Health Association, which was dissolved in 2015.
- Restores a portion of the provisions limiting insurer and HMO practices with respect to preexisting conditions.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Cummings offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Paragraph (d) of subsection (2) of section 408.909,
8 Florida Statutes, is amended to read:
9 408.909 Health flex plans.—
10 (2) DEFINITIONS.—As used in this section, the term:
11 (d) "Health care coverage" or "health flex plan coverage"
12 means health care services that are covered as benefits under an
13 approved health flex plan or that are otherwise provided, either
14 directly or through arrangements with other persons, via a
15 health flex plan on a prepaid per capita basis or on a prepaid
16 aggregate fixed-sum basis. The terms may also include one or
17 more of the excepted benefits under s. 627.6513(1)-(13)

18 ~~627.6561(5)(b), the benefits under s. 627.6561(5)(c), if offered~~
19 ~~separately, or the benefits under s. 627.6561(5)(d), if offered~~
20 ~~as independent, noncoordinated benefits~~.
21 Section 2. Section 409.817, Florida Statutes, is amended
22 to read:
23 409.817 Approval of health benefits coverage; financial
24 assistance.—In order for health insurance coverage to qualify
25 for premium assistance payments for an eligible child under ss.
26 409.810-409.821, the health benefits coverage must:
27 (1) Be certified by the Office of Insurance Regulation of
28 the Financial Services Commission under s. 409.818 as meeting,
29 exceeding, or being actuarially equivalent to the benchmark
30 benefit plan;
31 (2) Be guarantee issued;
32 (3) Be community rated;
33 (4) Not impose any preexisting condition exclusion for
34 covered benefits; ~~however, group health insurance plans may~~
35 ~~permit the imposition of a preexisting condition exclusion, but~~
36 ~~only insofar as it is permitted under s. 627.6561;~~
37 (5) Comply with the applicable limitations on premiums and
38 cost sharing in s. 409.816;
39 (6) Comply with the quality assurance and access standards
40 developed under s. 409.820; and
41 (7) Establish periodic open enrollment periods, which may
42 not occur more frequently than quarterly.

43 Section 3. Paragraph (b) of subsection (1) of section
44 624.123, Florida Statutes, is amended to read:
45 624.123 Certain international health insurance policies;
46 exemption from code.—
47 (1) International health insurance policies and
48 applications may be solicited and sold in this state at any
49 international airport to a resident of a foreign country. Such
50 international health insurance policies shall be solicited and
51 sold only by a licensed health insurance agent and underwritten
52 only by an admitted insurer. For purposes of this subsection:
53 (b) "International health insurance policy" means health
54 insurance, as provided ~~defined~~ in s. 627.6562(3)(a)2.
55 ~~627.6561(5)(a)2.~~, which is offered to an individual, covering
56 only a resident of a foreign country on an annual basis.
57 Section 4. Subsection (2) of section 627.402, Florida
58 Statutes, is amended to read:
59 627.402 Definitions.—As used in this part, the term:
60 (2) "Nongrandfathered health plan" is a health insurance
61 policy or health maintenance organization contract that is not a
62 grandfathered health plan and does not provide the benefits or
63 coverages specified under s. 627.6513(1)-(14) ~~627.6561(5)(b)-~~
64 ~~(e)~~.
65 Section 5. Subsection (3) of section 627.411, Florida
66 Statutes, is amended to read:
67 627.411 Grounds for disapproval.—

68 ~~(3)(a) For health insurance coverage as described in s.~~
69 ~~627.6561(5)(a)2., the minimum loss ratio standard of incurred~~
70 ~~claims to earned premium for the form shall be 65 percent.~~
71 ~~(b) Incurred claims are claims occurring within a fixed period,~~
72 ~~whether or not paid during the same period, under the terms of~~
73 ~~the policy period.~~
74 ~~1. Claims include scheduled benefit payments or services~~
75 ~~provided by a provider or through a provider network for dental,~~
76 ~~vision, disability, and similar health benefits.~~
77 ~~2. Claims do not include state assessments, taxes, company~~
78 ~~expenses, or any expense incurred by the company for the cost of~~
79 ~~adjusting and settling a claim, including the review,~~
80 ~~qualification, oversight, management, or monitoring of a claim~~
81 ~~or incentives or compensation to providers for other than the~~
82 ~~provisions of health care services.~~
83 ~~3. A company may at its discretion include costs that are~~
84 ~~demonstrated to reduce claims, such as fraud intervention~~
85 ~~programs or case management costs, which are identified in each~~
86 ~~filing, are demonstrated to reduce claims costs, and do not~~
87 ~~result in increasing the experience period loss ratio by more~~
88 ~~than 5 percent.~~
89 ~~4. For scheduled claim payments, such as disability income~~
90 ~~or long-term care, the incurred claims shall be the present~~
91 ~~value of the benefit payments discounted for continuance and~~
92 ~~interest.~~

93 Section 6. Section 627.6011, Florida Statutes, is amended
94 to read:
95 627.6011 Mandated coverages.—Mandatory health benefits
96 regulated under this chapter are not intended to apply to the
97 types of health benefit plans listed in s. 627.6513(1)-(14)
98 ~~627.6561(5)(b)-(e)~~, issued in any market, unless specifically
99 designated otherwise. For purposes of this section, the term
100 "mandatory health benefits" means those benefits set forth in
101 ss. 627.6401-627.64193, and any other mandatory treatment or
102 health coverages or benefits enacted on or after July 1, 2012.
103 Section 7. Paragraph (h) of subsection (1) of section
104 627.602, Florida Statutes, is amended to read:
105 627.602 Scope, format of policy.—
106 (1) Each health insurance policy delivered or issued for
107 delivery to any person in this state must comply with all
108 applicable provisions of this code and all of the following
109 requirements:
110 (h) Section 641.312 and the provisions of the Employee
111 Retirement Income Security Act of 1974, as implemented by 29
112 C.F.R. s. 2560.503-1, relating to internal grievances. This
113 paragraph does not apply to a health insurance policy that is
114 subject to the Subscriber Assistance Program under s. 408.7056
115 or to the types of benefits or coverages provided under s.
116 627.6513(1)-(14) ~~627.6561(5)(b)-(e)~~ issued in any market.
117 Section 8. Subsection (1) of section 627.642, Florida
118 Statutes, is amended to read:

119 627.642 Outline of coverage.—

120 (1) A policy offering benefits defined in s. 627.6513(1)-
121 (14) or a large group ~~no individual or family accident and~~
122 ~~health insurance~~ policy may not ~~shall~~ be delivered, or issued
123 for delivery, in this state unless:

124 (a) It is accompanied by an appropriate outline of
125 coverage; or

126 (b) An appropriate outline of coverage is completed and
127 delivered to the applicant at the time application is made, and
128 an acknowledgment of receipt or certificate of delivery of such
129 outline is provided to the insurer with the application.

130

131 In the case of a direct response, such as a written application
132 to the insurance company from an applicant, the outline of
133 coverage shall accompany the policy when issued.

134 Section 9. Subsections (1), (6), and (7) of section
135 627.6425, Florida Statutes, are amended to read:

136 627.6425 Renewability of individual coverage.—

137 (1) Except as otherwise provided in this section, an
138 insurer that provides individual health insurance coverage to an
139 individual shall renew or continue in force such coverage at the
140 option of the individual. For the purpose of this section, the
141 term "individual health insurance" means health insurance
142 coverage, as described in s. 624.603 ~~627.6561(5)(a)2.~~, offered
143 to an individual in this state, including certificates of
144 coverage offered to individuals in this state as part of a group

145 policy issued to an association outside this state, but the term
146 does not include short-term limited duration insurance or
147 excepted benefits specified in s. 627.6513(1)-(14) ~~subsection~~
148 ~~(6) or subsection (7)~~.
149 ~~(6) The requirements of this section do not apply to any~~
150 ~~health insurance coverage in relation to its provision of~~
151 ~~excepted benefits described in s. 627.6561(5)(b).~~
152 ~~(7) The requirements of this section do not apply to any~~
153 ~~health insurance coverage in relation to its provision of~~
154 ~~excepted benefits described in s. 627.6561(5)(c), (d), or (e),~~
155 ~~if the benefits are provided under a separate policy,~~
156 ~~certificate, or contract of insurance.~~
157 Section 10. Paragraph (b) of subsection (2) and subsection
158 (3) of section 627.6487, Florida Statutes, are amended to read:
159 627.6487 Guaranteed availability of individual health
160 insurance coverage to eligible individuals.—
161 (2) For the purposes of this section:
162 (b) "Individual health insurance" means health insurance,
163 as defined in s. 624.603 ~~627.6561(5)(a)2.~~, which is offered to
164 an individual, including certificates of coverage offered to
165 individuals in this state as part of a group policy issued to an
166 association outside this state, but the term does not include
167 short-term limited duration insurance or excepted benefits
168 specified in s. 627.6513(1)-(14) ~~627.6561(5)(b) or, if the~~
169 ~~benefits are provided under a separate policy, certificate, or~~

170 ~~contract, the term does not include excepted benefits specified~~
171 ~~in s. 627.6561(5)(c), (d), or (e)~~.
172 (3) For the purposes of this section, the term "eligible
173 individual" means an individual:
174 (a)1. For whom, as of the date on which the individual
175 seeks coverage under this section, the aggregate of the periods
176 of creditable coverage, as defined in s. 627.6562(3) ~~627.6561(5)~~
177 ~~and (6)~~, is 18 or more months; and
178 2.a. Whose most recent prior creditable coverage was under
179 a group health plan, governmental plan, or church plan, or
180 health insurance coverage offered in connection with any such
181 plan; or
182 b. Whose most recent prior creditable coverage was under
183 an individual plan issued in this state by a health insurer or
184 health maintenance organization, which coverage is terminated
185 due to the insurer or health maintenance organization becoming
186 insolvent or discontinuing the offering of all individual
187 coverage in the State of Florida, or due to the insured no
188 longer living in the service area in the State of Florida of the
189 insurer or health maintenance organization that provides
190 coverage through a network plan in the State of Florida;
191 (b) Who is not eligible for coverage under:
192 1. A group health plan, as defined in s. 2791 of the
193 Public Health Service Act;
194 2. A conversion policy or contract issued by an authorized
195 insurer or health maintenance organization under s. 627.6675 or

196 s. 641.3921, respectively, offered to an individual who is no
197 longer eligible for coverage under either an insured or self-
198 insured employer plan;
199 3. Part A or part B of Title XVIII of the Social Security
200 Act; or
201 4. A state plan under Title XIX of such act, or any
202 successor program, and does not have other health insurance
203 coverage;
204 (c) With respect to whom the most recent coverage within
205 the coverage period described in paragraph (a) was not
206 terminated based on a factor described in s. 627.6571(2)(a) or
207 (b), relating to nonpayment of premiums or fraud, unless such
208 nonpayment of premiums or fraud was due to acts of an employer
209 or person other than the individual;
210 (d) Who, having been offered the option of continuation
211 coverage under a COBRA continuation provision or under s.
212 627.6692, elected such coverage; and
213 (e) Who, if the individual elected such continuation
214 provision, has exhausted such continuation coverage under such
215 provision or program.
216 Section 11. Section 627.64871, Florida Statutes, is
217 repealed.
218 Section 12. Section 627.6512, Florida Statutes, is amended
219 to read:
220 627.6512 Exemption of certain group health insurance
221 policies.—Sections 627.6561, 627.65615, 627.65625, and 627.6571

222 do not apply to~~: (1)~~ any group insurance policy in relation to
223 its provision of ~~excepted~~ benefits described in s. 627.6513(1)-
224 (14) ~~627.6561(5)(b)~~.
225 ~~(2) Any group health insurance policy in relation to its~~
226 ~~provision of excepted benefits described in s. 627.6561(5)(c),~~
227 ~~if the benefits:~~
228 ~~(a) Are provided under a separate policy, certificate, or~~
229 ~~contract of insurance; or~~
230 ~~(b) Are otherwise not an integral part of the policy.~~
231 ~~(3) Any group health insurance policy in relation to its~~
232 ~~provision of excepted benefits described in s. 627.6561(5)(d),~~
233 ~~if all of the following conditions are met:~~
234 ~~(a) The benefits are provided under a separate policy,~~
235 ~~certificate, or contract of insurance;~~
236 ~~(b) There is no coordination between the provision of such~~
237 ~~benefits and any exclusion of benefits under any group policy~~
238 ~~maintained by the same policyholder; and~~
239 ~~(c) Such benefits are paid with respect to an event~~
240 ~~without regard to whether benefits are provided with respect to~~
241 ~~such an event under any group health policy maintained by the~~
242 ~~same policyholder.~~
243 ~~(4) Any group health policy in relation to its provision~~
244 ~~of excepted benefits described in s. 627.6561(5)(e), if the~~
245 ~~benefits are provided under a separate policy, certificate, or~~
246 ~~contract of insurance.~~

247 Section 13. Section 627.6513, Florida Statutes, is amended
248 to read:
249 627.6513 Scope.—Section 641.312 and the provisions of the
250 Employee Retirement Income Security Act of 1974, as implemented
251 by 29 C.F.R. s. 2560.503-1, relating to internal grievances,
252 apply to all group health insurance policies issued under this
253 part. This section does not apply to a group health insurance
254 policy that is subject to the Subscriber Assistance Program in
255 s. 408.7056 or to ~~the types of benefits or coverages provided~~
256 ~~under s. 627.6561(5)(b)-(e) issued in any market.~~:
257 (1) Coverage only for accident insurance or disability
258 income insurance, or any combination thereof.
259 (2) Coverage issued as a supplement to liability
260 insurance.
261 (3) Liability insurance, including general liability
262 insurance and automobile liability insurance.
263 (4) Workers' compensation or similar insurance.
264 (5) Automobile medical payment insurance.
265 (6) Credit-only insurance.
266 (7) Coverage for onsite medical clinics, including prepaid
267 health clinics under part II of chapter 641.
268 (8) Other similar insurance coverage, specified in rules
269 adopted by the commission, under which benefits for medical care
270 are secondary or incidental to other insurance benefits. To the
271 extent possible, such rules must be consistent with regulations

272 adopted by the United States Department of Health and Human
273 Services.
274 (9) Limited scope dental or vision benefits, if offered
275 separately.
276 (10) Benefits for long-term care, nursing home care, home
277 health care, or community-based care, or any combination
278 thereof, if offered separately.
279 (11) Other similar limited benefits, if offered
280 separately, as specified in rules adopted by the commission.
281 (12) Coverage only for a specified disease or illness, if
282 offered as independent, noncoordinated benefits.
283 (13) Hospital indemnity or other fixed indemnity
284 insurance, if offered as independent, noncoordinated benefits.
285 (14) Benefits provided through a Medicare supplemental
286 health insurance policy, as defined under s. 1882(g)(1) of the
287 Social Security Act, coverage supplemental to the coverage
288 provided under 10 U.S.C. chapter 55, and similar supplemental
289 coverage provided to coverage under a group health plan, which
290 are offered as a separate insurance policy and as independent,
291 noncoordinated benefits.
292 Section 14. Section 627.6561, Florida Statutes, is amended
293 to read:
294 627.6561 Preexisting conditions.—
295 (1) As used in this section, the term:
296 (a) "Enrollment date" means, with respect to an individual
297 covered under a group health policy, the date of enrollment of

298 the individual in the plan or coverage or, if earlier, the first
299 day of the waiting period of such enrollment.
300 (b) "Late enrollee" means, with respect to coverage under
301 a group health policy, a participant or beneficiary who enrolls
302 under the policy other than during:
303 1. The first period in which the individual is eligible to
304 enroll under the policy.
305 2. A special enrollment period, as provided under s.
306 627.65615.
307 (c) "Waiting period" means, with respect to a group health
308 policy and an individual who is a potential participant or
309 beneficiary of the policy, the period that must pass with
310 respect to the individual before the individual is eligible to
311 be covered for benefits under the terms of the policy.
312 (2) Subject to the exceptions specified in subsection (4),
313 an insurer that offers group health insurance coverage may, with
314 respect to a participant or beneficiary, impose a preexisting
315 condition exclusion only if:
316 (a) Such exclusion relates to a physical or mental
317 condition, regardless of the cause of the condition, for which
318 medical advice, diagnosis, care, or treatment was recommended or
319 received within the 6-month period ending on the enrollment
320 date;
321 (b) Such exclusion extends for a period of not more than
322 12 months, or 18 months in the case of a late enrollee, after
323 the enrollment date; and

324 (c) The period of any such preexisting condition exclusion
325 is reduced by the aggregate of the periods of creditable
326 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
327 applicable to the participant or beneficiary as of the
328 enrollment date.
329 (3) Genetic information may not be treated as a condition
330 described in paragraph (2)(a) in the absence of a diagnosis of
331 the condition related to such information.
332 (4)(a) Subject to paragraph (b), an insurer that offers
333 group health insurance coverage may not impose any preexisting
334 condition exclusion in the case of:
335 1. An individual who, as of the last day of the 30-day
336 period beginning with the date of birth, is covered under
337 creditable coverage.
338 2. A child who is adopted or placed for adoption before
339 attaining 18 years of age and who, as of the last day of the 30-
340 day period beginning on the date of the adoption or placement
341 for adoption, is covered under creditable coverage. This
342 provision does not apply to coverage before the date of such
343 adoption or placement for adoption.
344 3. Pregnancy.
345 (b) Subparagraphs 1. and 2. do not apply to an individual
346 after the end of the first 63-day period during all of which the
347 individual was not covered under any creditable coverage.

348 ~~(5)(a) The term, "creditable coverage," means, with~~
349 ~~respect to an individual, coverage of the individual under any~~
350 ~~of the following:~~
351 ~~1. A group health plan, as defined in s. 2791 of the~~
352 ~~Public Health Service Act.~~
353 ~~2. Health insurance coverage consisting of medical care,~~
354 ~~provided directly, through insurance or reimbursement, or~~
355 ~~otherwise and including terms and services paid for as medical~~
356 ~~care, under any hospital or medical service policy or~~
357 ~~certificate, hospital or medical service plan contract, or~~
358 ~~health maintenance contract offered by a health insurance~~
359 ~~issuer.~~
360 ~~3. Part A or part B of Title XVIII of the Social Security~~
361 ~~Act.~~
362 ~~4. Title XIX of the Social Security Act, other than~~
363 ~~coverage consisting solely of benefits under s. 1928.~~
364 ~~5. Chapter 55 of Title 10, United States Code.~~
365 ~~6. A medical care program of the Indian Health Service or~~
366 ~~of a tribal organization.~~
367 ~~7. The Florida Comprehensive Health Association or another~~
368 ~~state health benefit risk pool.~~
369 ~~8. A health plan offered under chapter 89 of Title 5,~~
370 ~~United States Code.~~
371 ~~9. A public health plan as defined by rules adopted by the~~
372 ~~commission. To the greatest extent possible, such rules must be~~

373 ~~consistent with regulations adopted by the United States~~
374 ~~Department of Health and Human Services.~~
375 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
376 ~~Act (22 U.S.C. s. 2504(e)).~~
377 ~~(b) Creditable coverage does not include coverage that~~
378 ~~consists solely of one or more or any combination thereof of the~~
379 ~~following excepted benefits:~~
380 ~~1. Coverage only for accident, or disability income~~
381 ~~insurance, or any combination thereof.~~
382 ~~2. Coverage issued as a supplement to liability insurance.~~
383 ~~3. Liability insurance, including general liability~~
384 ~~insurance and automobile liability insurance.~~
385 ~~4. Workers' compensation or similar insurance.~~
386 ~~5. Automobile medical payment insurance.~~
387 ~~6. Credit-only insurance.~~
388 ~~7. Coverage for onsite medical clinics, including prepaid~~
389 ~~health clinics under part II of chapter 641.~~
390 ~~8. Other similar insurance coverage, specified in rules~~
391 ~~adopted by the commission, under which benefits for medical care~~
392 ~~are secondary or incidental to other insurance benefits. To the~~
393 ~~extent possible, such rules must be consistent with regulations~~
394 ~~adopted by the United States Department of Health and Human~~
395 ~~Services.~~
396 ~~(c) The following benefits are not subject to the~~
397 ~~creditable coverage requirements, if offered separately:~~
398 ~~1. Limited scope dental or vision benefits.~~

399 ~~2. Benefits for long-term care, nursing home care, home~~
400 ~~health care, community-based care, or any combination thereof.~~
401 ~~3. Such other similar, limited benefits as are specified~~
402 ~~in rules adopted by the commission.~~
403 ~~(d) The following benefits are not subject to creditable~~
404 ~~coverage requirements if offered as independent, noncoordinated~~
405 ~~benefits:~~
406 ~~1. Coverage only for a specified disease or illness.~~
407 ~~2. Hospital indemnity or other fixed indemnity insurance.~~
408 ~~(e) Benefits provided through a Medicare supplemental~~
409 ~~health insurance, as defined under s. 1882(g)(1) of the Social~~
410 ~~Security Act, coverage supplemental to the coverage provided~~
411 ~~under chapter 55 of Title 10, United States Code, and similar~~
412 ~~supplemental coverage provided to coverage under a group health~~
413 ~~plan are not considered creditable coverage if offered as a~~
414 ~~separate insurance policy.~~
415 ~~(6)(a) A period of creditable coverage may not be counted,~~
416 ~~with respect to enrollment of an individual under a group health~~
417 ~~plan, if, after such period and before the enrollment date,~~
418 ~~there was a 63-day period during all of which the individual was~~
419 ~~not covered under any creditable coverage.~~
420 ~~(b) Any period during which an individual is in a waiting~~
421 ~~period for any coverage under a group health plan or for group~~
422 ~~health insurance coverage may not be taken into account in~~
423 ~~determining the 63-day period under paragraph (a) or paragraph~~
424 ~~(4)(b).~~

425 ~~(7)(a) Except as otherwise provided under paragraph (b),~~
426 ~~an insurer shall count a period of creditable coverage without~~
427 ~~regard to the specific benefits covered under the period.~~
428 ~~(b) An insurer may elect to count, as creditable coverage,~~
429 ~~coverage of benefits within each of several classes or~~
430 ~~categories of benefits specified in rules adopted by the~~
431 ~~commission rather than as provided under paragraph (a). To the~~
432 ~~extent possible, such rules must be consistent with regulations~~
433 ~~adopted by the United States Department of Health and Human~~
434 ~~Services. Such election shall be made on a uniform basis for all~~
435 ~~participants and beneficiaries. Under such election, an insurer~~
436 ~~shall count a period of creditable coverage with respect to any~~
437 ~~class or category of benefits if any level of benefits is~~
438 ~~covered within such class or category.~~
439 ~~(c) In the case of an election with respect to an insurer~~
440 ~~under paragraph (b), the insurer shall:~~
441 ~~1. Prominently state in 10-point type or larger in any~~
442 ~~disclosure statements concerning the policy, and state to each~~
443 ~~certificateholder at the time of enrollment under the policy,~~
444 ~~that the insurer has made such election; and~~
445 ~~2. Include in such statements a description of the effect~~
446 ~~of this election.~~
447 ~~(8)(a) Periods of creditable coverage with respect to an~~
448 ~~individual shall be established through presentation of~~
449 ~~certifications described in this subsection or in such other~~
450 ~~manner as is specified in rules adopted by the commission. To~~

451 ~~the extent possible, such rules must be consistent with~~
452 ~~regulations adopted by the United States Department of Health~~
453 ~~and Human Services.~~
454 ~~(b) An insurer that offers group health insurance coverage~~
455 ~~shall provide the certification described in paragraph (a):~~
456 ~~1. At the time an individual ceases to be covered under~~
457 ~~the plan or otherwise becomes covered under a COBRA continuation~~
458 ~~provision or continuation pursuant to s. 627.6692. 2. In the~~
459 ~~case of an individual becoming covered under a COBRA~~
460 ~~continuation provision or pursuant to s. 627.6692, at the time~~
461 ~~the individual ceases to be covered under such a provision.~~
462 ~~3. Upon the request on behalf of an individual made not~~
463 ~~later than 24 months after the date of cessation of the coverage~~
464 ~~described in this paragraph. The certification under~~
465 ~~subparagraph 1. may be provided, to the extent practicable, at a~~
466 ~~time consistent with notices required under any applicable COBRA~~
467 ~~continuation provision or continuation pursuant to s. 627.6692.~~
468 ~~(c) The certification described in this section is a~~
469 ~~written certification that must include:~~
470 ~~1. The period of creditable coverage of the individual~~
471 ~~under the policy and the coverage, if any, under such COBRA~~
472 ~~continuation provision or continuation pursuant to s. 627.6692;~~
473 ~~and~~
474 ~~2. The waiting period, if any, imposed with respect to the~~
475 ~~individual for any coverage under such policy.~~

476 ~~(d) In the case of an election described in subsection (7)~~
477 ~~by an insurer, if the insurer enrolls an individual for~~
478 ~~coverageunder the plan and the individual provides a~~
479 ~~certification of coverage of the individual, as provided in this~~
480 ~~subsection:~~
481 ~~1. Upon request of such insurer, the insurer that issued~~
482 ~~the certification provided by the individual shall promptly~~
483 ~~disclose to such requesting plan or insurer information on~~
484 ~~coverage of classes and categories of health benefits available~~
485 ~~under such insurer's plan or coverage.~~
486 ~~2. Such insurer may charge the requesting insurer for the~~
487 ~~reasonable cost of disclosing such information.~~
488 ~~(e) The commission shall adopt rules to prevent an~~
489 ~~insurer's failure to provide information under this subsection~~
490 ~~with respect to previous coverage of an individual from~~
491 ~~adversely affecting any subsequent coverage of the individual~~
492 ~~under another group health plan or health insurance coverage. To~~
493 ~~the greatest extent possible, such rules must be consistent with~~
494 ~~regulations adopted by the United States Department of Health~~
495 ~~and Human Services.~~
496 ~~(9)(a) Except as provided in paragraph (b), no period~~
497 ~~before July 1, 1996, shall be taken into account in determining~~
498 ~~creditable coverage.~~
499 ~~(b) The commission shall adopt rules that provide a~~
500 ~~process whereby individuals who need to establish creditable~~
501 ~~coverage for periods before July 1, 1996, and who would have~~

502 ~~such coverage credited but for paragraph (a), may be given~~
503 ~~credit for creditable coverage for such periods through the~~
504 ~~presentation of documents or other means. To the greatest extent~~
505 ~~possible, such rules must be consistent with regulations adopted~~
506 ~~by the United States Department of Health and Human Services.~~
507 ~~(10) Except as otherwise provided in this subsection,~~
508 ~~paragraph (8)(b) applies to events that occur on or after July~~
509 ~~1, 1996.~~
510 ~~(a) In no case is a certification required to be provided~~
511 ~~under paragraph (8)(b) prior to June 1, 1997.~~
512 ~~(b) In the case of an event that occurred on or after July~~
513 ~~1, 1996, and before October 1, 1996, a certification is not~~
514 ~~required to be provided under paragraph (8)(b), unless an~~
515 ~~individual, with respect to whom the certification is required~~
516 ~~to be made, requests such certification in writing.~~
517 ~~(11) In the case of an individual who seeks to establish~~
518 ~~creditable coverage for any period for which certification is~~
519 ~~not required because it relates to an event that occurred before~~
520 ~~July 1, 1996:~~
521 ~~(a) The individual may present other creditable coverage~~
522 ~~in order to establish the period of creditable coverage.~~
523 ~~(b) An insurer is not subject to any penalty or~~
524 ~~enforcement action with respect to the insurer's crediting, or~~
525 ~~not crediting, such coverage if the insurer has sought to comply~~
526 ~~in good faith with applicable provisions of this section.~~

527 ~~(12) For purposes of subsection (9), any plan amendment~~
528 ~~made pursuant to a collective bargaining agreement relating to~~
529 ~~the plan which amends the plan solely to conform to any~~
530 ~~requirement of this section may not be treated as a termination~~
531 ~~of such collective bargaining agreement.~~
532 ~~(13) This section does not apply to any health insurance~~
533 ~~coverage in relation to its provision of excepted benefits~~
534 ~~described in paragraph (5)(b).~~
535 ~~(14) This section does not apply to any health insurance~~
536 ~~coverage in relation to its provision of excepted benefits~~
537 ~~described in paragraphs (5)(c), (d), or (e), if the benefits are~~
538 ~~provided under a separate policy, certificate, or contract of~~
539 ~~insurance.~~
540 ~~(15) This section applies to health insurance coverage~~
541 ~~offered, sold, issued, renewed, or in effect on or after July 1,~~
542 ~~1997.~~
543 Section 15. Subsection (3) of section 627.6562, Florida
544 Statutes, is amended to read:
545 627.6562 Dependent coverage.—
546 (3) If, pursuant to subsection (2), a child is provided
547 coverage under the parent's policy after the end of the calendar
548 year in which the child reaches age 25 and coverage for the
549 child is subsequently terminated, the child is not eligible to
550 be covered under the parent's policy unless the child was
551 continuously covered by other creditable coverage without a gap
552 in coverage of more than 63 days.

553 (a) For the purposes of this subsection, the term
554 "creditable coverage" means, with respect to an individual,
555 coverage of the individual under any of the following: ~~has the~~
556 ~~same meaning as provided in s. 627.6561(5).~~
557 1. A group health plan, as defined in s. 2791 of the
558 Public Health Service Act.
559 2. Health insurance coverage consisting of medical care
560 provided directly through insurance or reimbursement or
561 otherwise, and including terms and services paid for as medical
562 care, under any hospital or medical service policy or
563 certificate, hospital or medical service plan contract, or
564 health maintenance contract offered by a health insurance
565 issuer.
566 3. Part A or part B of Title XVIII of the Social Security
567 Act.
568 4. Title XIX of the Social Security Act, other than
569 coverage consisting solely of benefits under s. 1928.
570 5. Title 10 U.S.C. chapter 55.
571 6. A medical care program of the Indian Health Service or
572 of a tribal organization.
573 7. The Florida Comprehensive Health Association or another
574 state health benefit risk pool.
575 8. A health plan offered under 5 U.S.C. chapter 89.
576 9. A public health plan as defined by rules adopted by the
577 commission. To the greatest extent possible, such rules must be

578 consistent with regulations adopted by the United States
579 Department of Health and Human Services.
580 10. A health benefit plan under s. 5(e) of the Peace Corps
581 Act, 22 U.S.C. s. 2504(e).
582 (b) Creditable coverage does not include coverage that
583 consists of one or more, or any combination thereof, of the
584 following excepted benefits:
585 1. Coverage only for accident insurance or disability
586 income insurance, or any combination thereof.
587 2. Coverage issued as a supplement to liability insurance.
588 3. Liability insurance, including general liability
589 insurance and automobile liability insurance.
590 4. Workers' compensation or similar insurance.
591 5. Automobile medical payment insurance.
592 6. Credit-only insurance.
593 7. Coverage for onsite medical clinics, including prepaid
594 health clinics under part II of chapter 641.
595 8. Other similar insurance coverage specified in rules
596 adopted by the commission under which benefits for medical care
597 are secondary or incidental to other insurance benefits. To the
598 extent possible, such rules must be consistent with regulations
599 adopted by the United States Department of Health and Human
600 Services.
601 (c) The following benefits are not subject to the
602 creditable coverage requirements, if offered separately:
603 1. Limited scope dental or vision benefits.

604 2. Benefits for long-term care, nursing home care, home
605 health care, or community-based care, or any combination
606 thereof.
607 3. Other similar, limited benefits specified in rules
608 adopted by the commission.
609 (d) The following benefits are not subject to creditable
610 coverage requirements if offered as independent, noncoordinated
611 benefits:
612 1. Coverage only for a specified disease or illness.
613 2. Hospital indemnity or other fixed indemnity insurance.
614 (e) Benefits provided through a Medicare supplemental
615 health insurance policy, as defined under s. 1882(g)(1) of the
616 Social Security Act, coverage supplemental to the coverage
617 provided under 10 U.S.C. chapter 55, and similar supplemental
618 coverage provided to coverage under a group health plan are not
619 considered creditable coverage if offered as a separate
620 insurance policy.
621 Section 16. Subsection (1) of section 627.65626, Florida
622 Statutes, is amended to read:
623 627.65626 Insurance rebates for healthy lifestyles.—
624 (1) Any rate, rating schedule, or rating manual for a
625 health insurance policy that provides creditable coverage as
626 defined in s. 627.6562(3) ~~627.6561(5)~~ filed with the office
627 shall provide for an appropriate rebate of premiums paid in the
628 last policy year, contract year, or calendar year when the
629 majority of members of a health plan have enrolled and

630 maintained participation in any health wellness, maintenance,
631 orimprovement program offered by the group policyholder and
632 health plan. The rebate may be based upon premiums paid in the
633 last calendar year or policy year. The group must provide
634 evidence of demonstrative maintenance or improvement of the
635 enrollees' health status as determined by assessments of agreed-
636 upon health status indicators between the policyholder and the
637 health insurer, including, but not limited to, reduction in
638 weight, body mass index, and smoking cessation. The group or
639 health insurer may contract with a third-party administrator to
640 assemble and report the health status required in this
641 subsection between the policyholder and the health insurer. Any
642 rebate provided by the health insurer is presumed to be
643 appropriate unless credible data demonstrates otherwise, or
644 unless the rebate program requires the insured to incur costs to
645 qualify for the rebate which equal or exceed the value of the
646 rebate, but the rebate may not exceed 10 percent of paid
647 premiums.
648 Section 17. Paragraphs (e), (l), and (n) of subsection
649 (3), paragraph (d) of subsection (5), and paragraph (b) of
650 subsection (6) of section 627.6699, Florida Statutes, are
651 amended to read:
652 627.6699 Employee Health Care Access Act.—
653 (3) DEFINITIONS.—As used in this section, the term:
654 (e) "Creditable coverage" has the same meaning ascribed in
655 s. 627.6562(3) ~~627.6561~~.

656 (l) "Late enrollee" means an eligible employee or
657 dependent who, with respect to coverage under a group health
658 policy, is a participant or beneficiary who enrolls under the
659 policy other than during:
660 1. The first period in which the individual is eligible to
661 enroll under the policy.
662 2. A special enrollment period, as provided under s.
663 627.65615 ~~as defined under s. 627.6561(1)(b)~~.
664 (n) "Modified community rating" means a method used to
665 develop carrier premiums which spreads financial risk across a
666 large population; allows the use of separate rating factors for
667 age, gender, family composition, tobacco usage, and geographic
668 area as determined under paragraph (5)(e) ~~(5)(f)~~; and allows
669 adjustments for~~:~~ claims experience, health status, or duration
670 of coverage as permitted under subparagraph (6)(b)5.; and
671 administrative and acquisition expenses as permitted under
672 subparagraph (6)(b)5.
673 (5) AVAILABILITY OF COVERAGE.—
674 (d) A health benefit plan covering small employers, issued
675 or renewed on or after January 1, 1994, must comply with the
676 following conditions:
677 1. All health benefit plans must be offered and issued on
678 a guaranteed-issue basis. Additional or increased benefits may
679 only be offered by riders.
680 ~~2. Paragraph (c) applies to health benefit plans issued to~~
681 ~~a small employer who has two or more eligible employees and to~~

682 ~~health benefit plans that are issued to a small employer who has~~
683 ~~fewer than two eligible employees and that cover an employee who~~
684 ~~has had creditable coverage continually to a date not more than~~
685 ~~63 days before the effective date of the new coverage.~~
686 2.~~3.~~ For health benefit plans that are issued to a small
687 employer who has fewer than two employees and that cover an
688 employee who has not been continually covered by creditable
689 coverage within 63 days before the effective date of the new
690 coverage, preexisting condition provisions must not exclude
691 coverage for a period beyond 24 months following the employee's
692 effective date of coverage and may relate only to:
693 a. Conditions that, during the 24-month period immediately
694 preceding the effective date of coverage, had manifested
695 themselves in such a manner as would cause an ordinarily prudent
696 person to seek medical advice, diagnosis, care, or treatment or
697 for which medical advice, diagnosis, care, or treatment was
698 recommended or received; or
699 b. A pregnancy existing on the effective date of coverage.
700 (6) RESTRICTIONS RELATING TO PREMIUM RATES.—
701 (b) For all small employer health benefit plans that are
702 subject to this section and issued by small employer carriers on
703 or after January 1, 1994, premium rates for health benefit plans
704 are subject to the following:
705 1. Small employer carriers must use a modified community
706 rating methodology in which the premium for each small employer
707 is determined solely on the basis of the eligible employee's and

708 eligible dependent's gender, age, family composition, tobacco
709 use, or geographic area as determined under paragraph (5)(e)
710 ~~(5)(f)~~ and in which the premium may be adjusted as permitted by
711 this paragraph. A small employer carrier is not required to use
712 gender as a rating factor for a nongrandfathered health plan.
713 2. Rating factors related to age, gender, family
714 composition, tobacco use, or geographic location may be
715 developed by each carrier to reflect the carrier's experience.
716 The factors used by carriers are subject to office review and
717 approval.
718 3. Small employer carriers may not modify the rate for a
719 small employer for 12 months from the initial issue date or
720 renewal date, unless the composition of the group changes or
721 benefits are changed. However, a small employer carrier may
722 modify the rate one time within the 12 months after the initial
723 issue date for a small employer who enrolls under a previously
724 issued group policy that has a common anniversary date for all
725 employers covered under the policy if:
726 a. The carrier discloses to the employer in a clear and
727 conspicuous manner the date of the first renewal and the fact
728 that the premium may increase on or after that date.
729 b. The insurer demonstrates to the office that
730 efficiencies in administration are achieved and reflected in the
731 rates charged to small employers covered under the policy.
732 4. A carrier may issue a group health insurance policy to
733 a small employer health alliance or other group association with

734 rates that reflect a premium credit for expense savings
735 attributable to administrative activities being performed by the
736 alliance or group association if such expense savings are
737 specifically documented in the insurer's rate filing and are
738 approved by the office. Any such credit may not be based on
739 different morbidity assumptions or on any other factor related
740 to the health status or claims experience of any person covered
741 under the policy. This subparagraph does not exempt an alliance
742 or group association from licensure for activities that require
743 licensure under the insurance code. A carrier issuing a group
744 health insurance policy to a small employer health alliance or
745 other group association shall allow any properly licensed and
746 appointed agent of that carrier to market and sell the small
747 employer health alliance or other group association policy. Such
748 agent shall be paid the usual and customary commission paid to
749 any agent selling the policy.
750 5. Any adjustments in rates for claims experience, health
751 status, or duration of coverage may not be charged to individual
752 employees or dependents. For a small employer's policy, such
753 adjustments may not result in a rate for the small employer
754 which deviates more than 15 percent from the carrier's approved
755 rate. Any such adjustment must be applied uniformly to the rates
756 charged for all employees and dependents of the small employer.
757 A small employer carrier may make an adjustment to a small
758 employer's renewal premium, up to 10 percent annually, due to
759 the claims experience, health status, or duration of coverage of

760 the employees or dependents of the small employer. If the
761 aggregate resulting from the application of such adjustment
762 exceeds the premium that would have been charged by application
763 of the approved modified community rate by 4 percent for the
764 current policy term, the carrier shall limit the application of
765 such adjustments only to minus adjustments. For any subsequent
766 policy term, if the total aggregate adjusted premium actually
767 charged does not exceed the premium that would have been charged
768 by application of the approved modified community rate by 4
769 percent, the carrier may apply both plus and minus adjustments.
770 A small employer carrier may provide a credit to a small
771 employer's premium based on administrative and acquisition
772 expense differences resulting from the size of the group. Group
773 size administrative and acquisition expense factors may be
774 developed by each carrier to reflect the carrier's experience
775 and are subject to office review and approval.
776 6. A small employer carrier rating methodology may include
777 separate rating categories for one dependent child, for two
778 dependent children, and for three or more dependent children for
779 family coverage of employees having a spouse and dependent
780 children or employees having dependent children only. A small
781 employer carrier may have fewer, but not greater, numbers of
782 categories for dependent children than those specified in this
783 subparagraph.
784 7. Small employer carriers may not use a composite rating
785 methodology to rate a small employer with fewer than 10

786 employees. For the purposes of this subparagraph, the term
787 "composite rating methodology" means a rating methodology that
788 averages the impact of the rating factors for age and gender in
789 the premiums charged to all of the employees of a small
790 employer.
791 8. A carrier may separate the experience of small employer
792 groups with fewer than 2 eligible employees from the experience
793 of small employer groups with 2-50 eligible employees for
794 purposes of determining an alternative modified community
795 rating.
796 a. If a carrier separates the experience of small employer
797 groups, the rate to be charged to small employer groups of fewer
798 than 2 eligible employees may not exceed 150 percent of the rate
799 determined for small employer groups of 2-50 eligible employees.
800 However, the carrier may charge excess losses of the experience
801 pool consisting of small employer groups with less than 2
802 eligible employees to the experience pool consisting of small
803 employer groups with 2-50 eligible employees so that all losses
804 are allocated and the 150-percent rate limit on the experience
805 pool consisting of small employer groups with less than 2
806 eligible employees is maintained.
807 b. Notwithstanding s. 627.411(1), the rate to be charged
808 to a small employer group of fewer than 2 eligible employees,
809 insured as of July 1, 2002, may be up to 125 percent of the rate
810 determined for small employer groups of 2-50 eligible employees

811 for the first annual renewal and 150 percent for subsequent
812 annual renewals.
813 9. A carrier shall separate the experience of
814 grandfathered health plans from nongrandfathered health plans
815 for determining rates.
816 Section 18. Subsection (1) and paragraph (c) of subsection
817 (2) of section 627.6741, Florida Statutes, are amended to read:
818 627.6741 Issuance, cancellation, nonrenewal, and
819 replacement.—
820 (1)(a) An insurer issuing Medicare supplement policies in
821 this state shall offer the opportunity of enrolling in a
822 Medicare supplement policy, without conditioning the issuance or
823 effectiveness of the policy on, and without discriminating in
824 the price of the policy based on, the medical or health status
825 or receipt of health care by the individual:
826 1. To any individual who is 65 years of age or older, or
827 under 65 years of age and eligible for Medicare by reason of
828 disability or end-stage renal disease, and who resides in this
829 state, upon the request of the individual during the 6-month
830 period beginning with the first month in which the individual
831 has attained 65 years of age and is enrolled in Medicare Part B,
832 or is eligible for Medicare by reason of a disability or end-
833 stage renal disease, and is enrolled in Medicare Part B; or
834 2. To any individual who is 65 years of age or older, or
835 under 65 years of age and eligible for Medicare by reason of a
836 disability or end-stage renal disease, who is enrolled in

837 Medicare Part B, and who resides in this state, upon the request
838 of the individual during the 2-month period following
839 termination of coverage under a group health insurance policy.
840 (b) The 6-month period to enroll in a Medicare supplement
841 policy for an individual who is under 65 years of age and is
842 eligible for Medicare by reason of disability or end-stage renal
843 disease and otherwise eligible under subparagraph (a)1. or
844 subparagraph (a)2. and first enrolled in Medicare Part B before
845 October 1, 2009, begins on October 1, 2009.
846 (c) A company that has offered Medicare supplement
847 policies to individuals under 65 years of age who are eligible
848 for Medicare by reason of disability or end-stage renal disease
849 before October 1, 2009, may, for one time only, effect a rate
850 schedule change that redefines the age bands of the premium
851 classes without activating the period of discontinuance required
852 by s. 627.410(6)(e)2.
853 (d) As a part of an insurer's rate filings, before and
854 including the insurer's first rate filing for a block of policy
855 forms in 2015, notwithstanding the provisions of s.
856 627.410(6)(e)3., an insurer shall consider the experience of the
857 policies or certificates for the premium classes including
858 individuals under 65 years of age and eligible for Medicare by
859 reason of disability or end-stage renal disease separately from
860 the balance of the block so as not to affect the other premium
861 classes. For filings in such time period only, credibility of
862 that experience shall be as follows: if a block of policy forms

863 has 1,250 or more policies or certificates in force in the age
864 band including ages under 65 years of age, full or 100-percent
865 credibility shall be given to the experience; and if fewer than
866 250 policies or certificates are in force, no or zero-percent
867 credibility shall be given. Linear interpolation shall be used
868 for in-force amounts between the low and high values. Florida-
869 only experience shall be used if it is 100-percent credible. If
870 Florida-only experience is not 100-percent credible, a
871 combination of Florida-only and nationwide experience shall be
872 used. If Florida-only experience is zero-percent credible,
873 nationwide experience shall be used. The insurer may file its
874 initial rates and any rate adjustment based upon the experience
875 of these policies or certificates or based upon expected claim
876 experience using experience data of the same company, other
877 companies in the same or other states, or using data publicly
878 available from the Centers for Medicaid and Medicare Services if
879 the insurer's combined Florida and nationwide experience is not
880 100-percent credible, separate from the balance of all other
881 Medicare supplement policies.
882
883 A Medicare supplement policy issued to an individual under
884 subparagraph (a)1. or subparagraph (a)2. may not exclude
885 benefits based on a preexisting condition if the individual has
886 a continuous period of creditable coverage, as defined in s.
887 627.6562(3) ~~627.6561(5)~~, of at least 6 months as of the date of
888 application for coverage.

889 (2) For both individual and group Medicare supplement
890 policies:
891 (c) If a Medicare supplement policy or certificate
892 replaces another Medicare supplement policy or certificate or
893 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
894 the replacing insurer shall waive any time periods applicable to
895 preexisting conditions, waiting periods, elimination periods,
896 and probationary periods in the new Medicare supplement policy
897 for similar benefits to the extent such time was spent under the
898 original policy~~, subject to the requirements of s. 627.6561(6)-~~
899 ~~(11)~~.
900 Section 19. Subsection (2) and paragraph (a) of subsection
901 (40) of section 641.31, Florida Statutes, are amended to read:
902 641.31 Health maintenance contracts.—
903 (2) The rates charged by any health maintenance
904 organization to its subscribers shall not be excessive,
905 inadequate, or unfairly discriminatory or follow a rating
906 methodology that is inconsistent, indeterminate, or ambiguous or
907 encourages misrepresentation or misunderstanding. ~~A law~~
908 ~~restricting or limiting deductibles, coinsurance, copayments, or~~
909 ~~annual or lifetime maximum payments shall not apply to any~~
910 ~~health maintenance organization contract that provides coverage~~
911 ~~as described in s. 641.31071(5)(a)2., offered or delivered to an~~
912 ~~individual or a group of 51 or more persons.~~ The commission, in
913 accordance with generally accepted actuarial practice as applied
914 to health maintenance organizations, may define by rule what

915 constitutes excessive, inadequate, or unfairly discriminatory
916 rates and may require whatever information it deems necessary to
917 determine that a rate or proposed rate meets the requirements of
918 this subsection.
919 (40)(a) Any group rate, rating schedule, or rating manual
920 for a health maintenance organization policy, which provides
921 creditable coverage as defined in s. 627.6562(3) ~~627.6561(5)~~,
922 filed with the office shall provide for an appropriate rebate of
923 premiums paid in the last policy year, contract year, or
924 calendar year when the majority of members of a health plan are
925 enrolled in and have maintained participation in any health
926 wellness, maintenance, or improvement program offered by the
927 group contract holder. The group must provide evidence of
928 demonstrative maintenance or improvement of his or her health
929 status as determined by assessments of agreed-upon health status
930 indicators between the group and the health insurer, including,
931 but not limited to, reduction in weight, body mass index, and
932 smoking cessation. Any rebate provided by the health maintenance
933 organization is presumed to be appropriate unless credible data
934 demonstrates otherwise, or unless the rebate program requires
935 the insured to incur costs to qualify for the rebate which
936 equals or exceeds the value of the rebate but the rebate may not
937 exceed 10 percent of paid premiums.
938 Section 20. Section 651.31071, Florida Statutes, is
939 amended to read:
940 641.31071 Preexisting conditions.—

941 (1) As used in this section, the term:
942 (a) "Enrollment date" means, with respect to an individual
943 covered under a group health maintenance organization contract,
944 the date of enrollment of the individual in the plan or coverage
945 or, if earlier, the first day of the waiting period of such
946 enrollment.
947 (b) "Late enrollee" means, with respect to coverage under
948 a group health maintenance organization contract, a participant
949 or beneficiary who enrolls under the contract other than during:
950 1. The first period in which the individual is eligible to
951 enroll under the plan.
952 2. A special enrollment period, as provided under s.
953 641.31072.
954 (c) "Waiting period" means, with respect to a group health
955 maintenance organization contract and an individual who is a
956 potential participant or beneficiary under the contract, the
957 period that must pass with respect to the individual before the
958 individual is eligible to be covered for benefits under the
959 terms of the contract.
960 (2) Subject to the exceptions specified in subsection (4),
961 a health maintenance organization that offers group coverage,
962 may, with respect to a participant or beneficiary, impose a
963 preexisting condition exclusion only if:
964 (a) Such exclusion relates to a physical or mental
965 condition, regardless of the cause of the condition, for which
966 medical advice, diagnosis, care, or treatment was recommended or

967 received within the 6-month period ending on the enrollment
968 date;
969 (b) Such exclusion extends for a period of not more than
970 12 months, or 18 months in the case of a late enrollee, after
971 the enrollment date; and
972 (c) The period of any such preexisting condition exclusion
973 is reduced by the aggregate of the periods of creditable
974 coverage, as defined in s. 627.6562(3) ~~subsection (5)~~,
975 applicable to the participant or beneficiary as of the
976 enrollment date.
977 (3) Genetic information shall not be treated as a
978 condition described in paragraph (2)(a) in the absence of a
979 diagnosis of the condition related to such information.
980 (4)(a) Subject to paragraph (b), a health maintenance
981 organization that offers group coverage may not impose any
982 preexisting condition exclusion in the case of:
983 1. An individual who, as of the last day of the 30-day
984 period beginning with the date of birth, is covered under
985 creditable coverage.
986 2. A child who is adopted or placed for adoption before
987 attaining 18 years of age and who, as of the last day of the 30-
988 day period beginning on the date of the adoption or placement
989 for adoption, is covered under creditable coverage. This
990 provision shall not apply to coverage before the date of such
991 adoption or placement for adoption.
992 3. Pregnancy.

993 (b) Subparagraphs (a)1. and 2. do not apply to an
994 individual after the end of the first 63-day period during all
995 of which the individual was not covered under any creditable
996 coverage.
997 ~~(5)(a) The term "creditable coverage" means, with respect~~
998 ~~to an individual, coverage of the individual under any of the~~
999 ~~following:~~
1000 ~~1. A group health plan, as defined in s. 2791 of the~~
1001 ~~Public Health Service Act.~~
1002 ~~2. Health insurance coverage consisting of medical care,~~
1003 ~~provided directly, through insurance or reimbursement or~~
1004 ~~otherwise, and including terms and services paid for as medical~~
1005 ~~care, under any hospital or medical service policy or~~
1006 ~~certificate, hospital or medical service plan contract, or~~
1007 ~~health maintenance contract offered by a health insurance~~
1008 ~~issuer.~~
1009 ~~3. Part A or part B of Title XVIII of the Social Security~~
1010 ~~Act.~~
1011 ~~4. Title XIX of the Social Security Act, other than~~
1012 ~~coverage consisting solely of benefits under s. 1928.~~
1013 ~~5. Chapter 55 of Title 10, United States Code.~~
1014 ~~6. A medical care program of the Indian Health Service or~~
1015 ~~of a tribal organization.~~
1016 ~~7. The Florida Comprehensive Health Association or another~~
1017 ~~state health benefit risk pool.~~

1018 ~~8. A health plan offered under chapter 89 of Title 5,~~
1019 ~~United States Code.~~
1020 ~~9. A public health plan as defined by rule of the~~
1021 ~~commission. To the greatest extent possible, such rules must be~~
1022 ~~consistent with regulations adopted by the United States~~
1023 ~~Department of Health and Human Services.~~
1024 ~~10. A health benefit plan under s. 5(e) of the Peace Corps~~
1025 ~~Act (22 U.S.C. s. 2504(e)).~~
1026 ~~(b) Creditable coverage does not include coverage that~~
1027 ~~consists solely of one or more or any combination thereof of the~~
1028 ~~following excepted benefits:~~
1029 ~~1. Coverage only for accident, or disability income~~
1030 ~~insurance, or any combination thereof.~~
1031 ~~2. Coverage issued as a supplement to liability insurance.~~
1032 ~~3. Liability insurance, including general liability~~
1033 ~~insurance and automobile liability insurance.~~
1034 ~~4. Workers' compensation or similar insurance.~~
1035 ~~5. Automobile medical payment insurance.~~
1036 ~~6. Credit-only insurance.~~
1037 ~~7. Coverage for onsite medical clinics.~~
1038 ~~8. Other similar insurance coverage, specified in rules~~
1039 ~~adopted by the commission, under which benefits for medical care~~
1040 ~~are secondary or incidental to other insurance benefits. To the~~
1041 ~~greatest extent possible, such rules must be consistent with~~
1042 ~~regulations adopted by the United States Department of Health~~
1043 ~~and Human Services.~~

1044 ~~(c) The following benefits are not subject to the~~
1045 ~~creditable coverage requirements, if offered separately:~~
1046 ~~1. Limited scope dental or vision benefits.~~
1047 ~~2. Benefits or long-term care, nursing home care, home~~
1048 ~~health care, community-based care, or any combination of these.~~
1049 ~~3. Such other similar, limited benefits as are specified~~
1050 ~~in rules adopted by the commission. To the greatest extent~~
1051 ~~possible, such rules must be consistent with regulations adopted~~
1052 ~~by the United States Department of Health and Human Services.~~
1053 ~~(d) The following benefits are not subject to creditable~~
1054 ~~coverage requirements if offered as independent, noncoordinated~~
1055 ~~benefits:~~
1056 ~~1. Coverage only for a specified disease or illness.~~
1057 ~~2. Hospital indemnity or other fixed indemnity insurance.~~
1058 ~~(e) Benefits provided through Medicare supplemental health~~
1059 ~~insurance, as defined under s. 1882(g)(1) of the Social Security~~
1060 ~~Act, coverage supplemental to the coverage provided under~~
1061 ~~chapter 55 of Title 10, United States Code, and similar~~
1062 ~~supplemental coverage provided to coverage under a group health~~
1063 ~~plan are not considered creditable coverage if offered as a~~
1064 ~~separate insurance policy.~~
1065 ~~(6)(a) A period of creditable coverage may not be counted,~~
1066 ~~with respect to enrollment of an individual under a group health~~
1067 ~~maintenance organization contract, if, after such period and~~
1068 ~~before the enrollment date, there was a 63-day period during all~~

1069 ~~of which the individual was not covered under any creditable~~
1070 ~~coverage.~~
1071 ~~(b) Any period during which an individual is in a waiting~~
1072 ~~period, or in an affiliation period as defined in subsection~~
1073 ~~(9), for any coverage under a group health maintenance~~
1074 ~~organization contract may not be taken into account in~~
1075 ~~determining the 63-day period under paragraph (a) or paragraph~~
1076 ~~(4)(b).~~
1077 ~~(7)(a) Except as otherwise provided under paragraph (b), a~~
1078 ~~health maintenance organization shall count a period of~~
1079 ~~creditable coverage without regard to the specific benefits~~
1080 ~~covered under the period.~~
1081 ~~(b) A health maintenance organization may elect to count~~
1082 ~~as creditable coverage, coverage of benefits within each of~~
1083 ~~several classes or categories of benefits specified in rules~~
1084 ~~adopted by the commission rather than as provided under~~
1085 ~~paragraph (a). Such election shall be made on a uniform basis~~
1086 ~~for all participants and beneficiaries. Under such election, a~~
1087 ~~health maintenance organization shall count a period of~~
1088 ~~creditable coverage with respect to any class or category of~~
1089 ~~benefits if any level of benefits is covered within such class~~
1090 ~~or category.~~
1091 ~~(c) In the case of an election with respect to a health~~
1092 ~~maintenance organization under paragraph (b), the organization~~
1093 ~~shall:~~

1094 ~~1. Prominently state in 10-point type or larger in any~~
1095 ~~disclosure statements concerning the contract, and state to each~~
1096 ~~enrollee at the time of enrollment under the contract, that the~~
1097 ~~organization has made such election; and~~
1098 ~~2. Include in such statements a description of the effect~~
1099 ~~of this election.~~
1100 ~~(8)(a) Periods of creditable coverage with respect to an~~
1101 ~~individual shall be established through presentation of~~
1102 ~~certifications described in this subsection or in such other~~
1103 ~~manner as may be specified in rules adopted by the commission.~~
1104 ~~(b) A health maintenance organization that offers group~~
1105 ~~coverage shall provide the certification described in paragraph~~
1106 ~~(a):~~
1107 ~~1. At the time an individual ceases to be covered under~~
1108 ~~the plan or otherwise becomes covered under a COBRA continuation~~
1109 ~~provision or continuation pursuant to s. 627.6692.~~
1110 ~~2. In the case of an individual becoming covered under a~~
1111 ~~COBRA continuation provision or pursuant to s. 627.6692, at the~~
1112 ~~time the individual ceases to be covered under such a provision.~~
1113 ~~3. Upon the request on behalf of an individual made not~~
1114 ~~later than 24 months after the date of cessation of the coverage~~
1115 ~~described in this paragraph.~~
1116
1117 ~~The certification under subparagraph 1. may be provided, to the~~
1118 ~~extent practicable, at a time consistent with notices required~~

1119 ~~under any applicable COBRA continuation provision or~~
1120 ~~continuation pursuant to s. 627.6692.~~
1121 ~~(c) The certification is a written certification of:~~
1122 ~~1. The period of creditable coverage of the individual~~
1123 ~~under the contract and the coverage, if any, under such COBRA~~
1124 ~~continuation provision or continuation pursuant to s. 627.6692;~~
1125 ~~and~~
1126 ~~2. The waiting period, if any, imposed with respect to the~~
1127 ~~individual for any coverage under such contract.~~
1128 ~~(d) In the case of an election described in subsection (7)~~
1129 ~~by a health maintenance organization, if the organization~~
1130 ~~enrolls an individual for coverage under the plan and the~~
1131 ~~individual provides a certification of coverage of the~~
1132 ~~individual, as provided by this subsection:~~
1133 ~~1. Upon request of such health maintenance organization,~~
1134 ~~the insurer or health maintenance organization that issued the~~
1135 ~~certification provided by the individual shall promptly disclose~~
1136 ~~to such requesting organization information on coverage of~~
1137 ~~classes and categories of health benefits available under such~~
1138 ~~insurer's or health maintenance organization's plan or coverage.~~
1139 ~~2. Such insurer or health maintenance organization may~~
1140 ~~charge the requesting organization for the reasonable cost of~~
1141 ~~disclosing such information.~~
1142 ~~(e) The commission shall adopt rules to prevent an~~
1143 ~~insurer's or health maintenance organization's failure to~~
1144 ~~provide information under this subsection with respect to~~

1145 ~~previous coverage of an individual from adversely affecting any~~
1146 ~~subsequent coverage of the individual under another group health~~
1147 ~~plan or health maintenance organization coverage.~~
1148 ~~(9)(a) A health maintenance organization may provide for~~
1149 ~~an affiliation period with respect to coverage through the~~
1150 ~~organization only if:~~
1151 ~~1. No preexisting condition exclusion is imposed with~~
1152 ~~respect to coverage through the organization;~~
1153 ~~2. The period is applied uniformly without regard to any~~
1154 ~~health status-related factors; and~~
1155 ~~3. Such period does not exceed 2 months or 3 months in the~~
1156 ~~case of a late enrollee.~~
1157 ~~(b) For the purposes of this section, the term~~
1158 ~~"affiliation period" means a period that, under the terms of the~~
1159 ~~coverage offered by the health maintenance organization, must~~
1160 ~~expire before the coverage becomes effective. The organization~~
1161 ~~is not required to provide health care services or benefits~~
1162 ~~during such period, and no premium may be charged to the~~
1163 ~~participant or beneficiary for any coverage during the period.~~
1164 ~~Such period begins on the enrollment date and runs concurrently~~
1165 ~~with any waiting period under the plan.~~
1166 ~~(c) As an alternative to the method authorized by~~
1167 ~~paragraph (a), a health maintenance organization may address~~
1168 ~~adverse selection in a method approved by the office.~~

1169 ~~(10)(a) Except as provided in paragraph (b), no period~~
1170 ~~before July 1, 1996, shall be taken into account in determining~~
1171 ~~creditable coverage.~~
1172 ~~(b) The commission shall adopt rules that provide a~~
1173 ~~process whereby individuals who need to establish creditable~~
1174 ~~coverage for periods before July 1, 1996, and who would have~~
1175 ~~such coverage credited but for paragraph (a), may be given~~
1176 ~~credit for creditable coverage for such periods through the~~
1177 ~~presentation of documents or other means.~~
1178 ~~(11) Except as otherwise provided in this subsection, the~~
1179 ~~requirements of paragraph (8)(b) shall apply to events that~~
1180 ~~occur on or after July 1, 1996.~~
1181 ~~(a) In no case is a certification required to be provided~~
1182 ~~under paragraph (8)(b) prior to June 1, 1997.~~
1183 ~~(b) In the case of an event that occurs on or after July~~
1184 ~~1, 1996, and before October 1, 1996, a certification is not~~
1185 ~~required to be provided under paragraph (8)(b), unless an~~
1186 ~~individual, with respect to whom the certification is required~~
1187 ~~to be made, requests such certification in writing.~~
1188 ~~(12) In the case of an individual who seeks to establish~~
1189 ~~creditable coverage for any period for which certification is~~
1190 ~~not required because it relates to an event occurring before~~
1191 ~~July 1, 1996:~~
1192 ~~(a) The individual may present other creditable coverage~~
1193 ~~in order to establish the period of creditable coverage.~~

1194 ~~(b) A health maintenance organization is not subject to~~
1195 ~~any penalty or enforcement action with respect to the~~
1196 ~~organization's crediting, or not crediting, such coverage if the~~
1197 ~~organization has sought to comply in good faith with applicable~~
1198 ~~provisions of this section.~~
1199 ~~(13) For purposes of subsection (10), any plan amendment~~
1200 ~~made pursuant to a collective bargaining agreement relating to~~
1201 ~~the plan which amends the plan solely to conform to any~~
1202 ~~requirement of this section may not be treated as a termination~~
1203 ~~of such collective bargaining agreement.~~
1204 Section 21. Subsections (1), (3), and (4) of section
1205 641.31074, Florida Statutes, are amended to read:
1206 641.31074 Guaranteed renewability of coverage.—
1207 (1) Except as otherwise provided in this section, a health
1208 maintenance organization that issues a ~~group~~ health insurance
1209 contract must renew or continue in force such coverage at the
1210 option of the contract holder.
1211 (3)(a) A health maintenance organization may discontinue
1212 offering a particular contract form ~~for group coverage offered~~
1213 ~~in the small group market or large group market~~ only if:
1214 1. The health maintenance organization provides notice to
1215 each contract holder provided coverage of this form in such
1216 market, and participants and beneficiaries covered under such
1217 coverage, of such discontinuation at least 90 days prior to the
1218 date of the nonrenewal of such coverage;

1219 2. The health maintenance organization offers to each
1220 contract holder provided coverage of this form in such market
1221 the option to purchase all, or in the case of the large group
1222 market, any other health insurance coverage currently being
1223 offered by the health maintenance organization in such market;
1224 and
1225 3. In exercising the option to discontinue coverage of
1226 this form and in offering the option of coverage under
1227 subparagraph 2., the health maintenance organization acts
1228 uniformly without regard to the claims experience of those
1229 contract holders or any health-status-related factor that
1230 relates to any participants or beneficiaries covered or new
1231 participants or beneficiaries who may become eligible for such
1232 coverage.
1233 (b)1. In any case in which a health maintenance
1234 organization elects to discontinue offering all coverage in the
1235 individual market, small group market, or the large group
1236 market, or ~~both~~ any combination thereof, in this state, coverage
1237 may be discontinued by the insurer only if:
1238 a. The health maintenance organization provides notice to
1239 the office and to each contract holder, and participants and
1240 beneficiaries covered under such coverage, of such
1241 discontinuation at least 180 days prior to the date of the
1242 nonrenewal of such coverage; and

1243 b. All health insurance issued or delivered for issuance
1244 in this state in such market is discontinued and coverage under
1245 such health insurance coverage in such market is not renewed.
1246 2. In the case of a discontinuation under subparagraph 1.
1247 in a market, the health maintenance organization may not provide
1248 for the issuance of any health maintenance organization contract
1249 coverage in the market in this state during the 5-year period
1250 beginning on the date of the discontinuation of the last
1251 insurance contract not renewed.
1252 (4) At the time of coverage renewal, a health maintenance
1253 organization may modify the coverage for a product offered:
1254 (a) In the large group market; ~~or~~
1255 (b) In the small group market if, for coverage that is
1256 available in such market other than only through one or more
1257 bona fide associations, as defined in s. 627.6571(5), such
1258 modification is consistent with s. 627.6699 and effective on a
1259 uniform basis among group health plans with that product; or
1260 (c) In the individual market so long as such modification
1261 is consistent with the laws of this state and effective on a
1262 uniform basis among all individuals with that policy form.
1263 Section 22. Section 641.312, Florida Statutes, is amended
1264 to read:
1265 641.312 Scope.—The Office of Insurance Regulation may
1266 adopt rules to administer the provisions of the National
1267 Association of Insurance Commissioners' Uniform Health Carrier
1268 External Review Model Act, issued by the National Association of

1269 Insurance Commissioners and dated April 2010. This section does
1270 not apply to a health maintenance contract that is subject to
1271 the Subscriber Assistance Program under s. 408.7056 or to the
1272 types of benefits or coverages provided under s. 627.6513(1)-
1273 (14) ~~627.6561(5)(b)-(e)~~ issued in any market.
1274 Section 23. This act shall take effect July 1, 2016
1275
1276 ----------
1277 **T I T L E A M E N D M E N T**
1278 Remove everything before the enacting clause and insert:
1279 A bill to be entitled
1280 An act relating to health plan regulatory administration;
1281 amending s. 408.909, F.S.; redefining the term "health care
1282 coverage" or "health flex plan coverage"; amending s. 409.817,
1283 F.S.; deleting a provision authorizing group insurance plans to
1284 impose a certain preexisting condition exclusion; amending s.
1285 624.123, F.S.; conforming a cross-reference; amending s.
1286 627.402, F.S.; redefining the term "nongrandfathered health
1287 plan"; amending s. 627.411, F.S.; deleting a provision relating
1288 to a minimum loss ratio standard for specified health insurance
1289 coverage; deleting provisions specifying certain incurred
1290 claims; amending ss. 627.6011 and 627.602, incurred claims;
1291 amending ss. 627.6011 and 627.602, F.S.; conforming cross-
1292 references; amending s. 627.642, F.S.; revising the policies to
1293 which certain outline of coverage requirements apply; amending
1294 s. 627.6425, F.S.; redefining the term "individual health

1295 insurance"; revising applicability; amending s. 627.6487, F.S.;
1296 redefining terms; repealing s. 627.64871, F.S., relating to
1297 certification of coverage; amending s. 627.6512, F.S.; revising
1298 a provision specifying that certain sections of the Florida
1299 Insurance Code do not apply to a group health insurance policy
1300 as that policy relates to specified benefits, under certain
1301 circumstances; amending s. 627.6513, F.S.; excluding
1302 applicability as to certain types of benefits or coverages;
1303 amending s. 627.6561, F.S.; revising conditions under which an
1304 insurer may impose a preexisting condition exclusion; deleting
1305 the definition of the term "creditable coverage"; removing
1306 application and reporting requirements relating to creditable
1307 coverage to conform to changes made by the act; amending s.
1308 627.6562, F.S.; redefining the term "creditable coverage";
1309 providing exceptions andapplicability; amending s. 627.65626,
1310 F.S.; conforming a cross-reference; amending s. 627.6699, F.S.;
1311 redefining terms; deleting a provision that requires a certain
1312 health benefit plan to comply with specified preexisting
1313 condition provisions; conforming provisions to changes made by
1314 the act; amending s. 627.6741, F.S.; conforming cross-
1315 references; conforming a provision to changes made by the act;
1316 amending s. 641.31, F.S.; deleting a provision specifying that a
1317 law restricting or limiting deductibles, coinsurance,
1318 copayments, or annual or lifetime maximum payments may not apply
1319 to a certain health maintenance organization contract;
1320 conforming a cross-reference; amending s. 641.31071, F.S.;

1321 conforming a cross-reference; amending s. 641.31074, F.S.;
1322 revising provisions relating to guaranteed renewability of
1323 coverage; amending s. 641.312, F.S.; conforming a cross-
1324 reference; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 965 Firesafety
SPONSOR(S): Harrison
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1164

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Yaffe DY	Luczynski MZ
2) Appropriations Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill amends current law, relating to the uniform firesafety standards for assisted living facilities. The bill repeals fire code requirements that are more than 20 years old and repetitious of those contained in the 1994 Life Safety Code. The bill updates the firesafety requirements for assisted living facilities by replacing the reference to the 1994 edition of the Life Safety Code with a reference to the current edition of the National Fire Protection Association, Life Safety Code, NFPA 101 and 101A. This will allow assisted living facilities to utilize modern advancements in safety, technology, materials, and building design.

The bill removes the requirements that the Office of the State Fire Marshall provide training and education to the employees of the Agency for Health Care Administration and local government inspectors.

The bill adds "a utility," in addition to "a local government," to the entities prohibited from charging in excess of the actual expense incurred in the installation and maintenance of an automatic fire sprinkler system.

The bill has an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Assisted Living Facilities
An assisted living facility (ALF) is any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more *personal services* for a period exceeding 24 hours to one or more adults.[1] Personal services are direct physical assistance with, or supervision of, the *activities of daily living* and the self-administration of medication.[2] Activities of daily living are functions and tasks of self-care such as ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[3]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility. An ALF must be licensed by the Agency for Health Care Administration (AHCA), pursuant to part I of ch. 429, F.S., and part II of ch. 408, F.S. According to a web search on the AHCA website, there are 3,083 licensed ALFs in Florida.[4]

Firesafety
The Department of Elderly Affairs (DOEA), in consultation with the AHCA, the Department of Children and Families, and the Department of Health, are required to promulgate rules and firesafety procedures to ensure the safety of residents living within an ALF community. The State Fire Marshall is required to apply the NFPA Life Safety Code from 1994 to establish and enforce uniform firesafety standards for ALFs, in cooperation with the AHCA, the DOEA, and the Department of Health. In addition, the Office of the State Fire Marshal is tasked with the responsibility of providing training and education on the proper application of Chapter 5, NFPA Life Safety Code 101A, 1995 edition, to its employees, the employees of the AHCA, and local government inspectors, who are responsible for regulating ALF communities.

Section 429.41, F.S., which governs ALF firesafety, mirrors the firesafety standards of the 1994 Life Safety Code, with the exception of the State Fire Marshall's training and education requirements. The 1994 code does not contain the safety improvements that have been developed and adopted into the more recent editions of the code over the past 20 years. As a result, ALFs are prohibited from utilizing modern advancements in firesafety which hinders the construction and redevelopment of ALFs and forces builders to work around the outdated safety codes in an effort to build safe structures.[5]

Additionally, "a local government" that installs and maintains an automatic fire sprinkler system in an ALF is prohibited from charging in excess of the actual expense incurred in the installation and maintenance of such system, as of January 1, 1996.

Effect of Proposed Changes

The bill repeals fire code requirements that are more than 20 years old and repetitious of those contained in the 1994 Life Safety Code. Through this significant repeal of the statutory language, the

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[1] s. 429.02(5), F.S.
[2] s. 429.02(17), F.S.
[3] s. 429.02(1), F.S.
[4] AGENCY FOR HEALTH CARE ADMINISTRATION, *Facility/Provider Locator*, http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx (last visited Jan. 29, 2016).
[5] Email from Susan E. Anderson, Vice President of Public Policy, Florida Assisted Living Federation of America, RE: HB Florida Insurance & Banking Subcommittee -- House Bill 965 Inquiry (Jan. 29, 2016).

DFS indicates that inconsistencies between the Florida Building Code and the Fire Prevention Code will be removed.[6] Additionally, the bill updates the firesafety requirements for ALFs by replacing the reference to the 1994 edition of the Life Safety Code with a reference to the current edition of the National Fire Protection Association, Life Safety Code, NFPA 101 and 101A. As s. 633.202, F.S., directs the State Fire Marshall to adopt a new edition of the Florida Fire Prevention Code every third year, ALFs will be able to utilize modern advancements in safety, technology, materials, and building design.

The bill removes the requirements that the Office of the State Fire Marshall provide training and education to the employees of the AHCA and local government inspectors. This training does not presently occur.[7]

The bill adds "a utility," in addition to "a local government," to the entities prohibited from charging in excess of the actual expense incurred in the installation and maintenance of an automatic fire sprinkler system. The bill removes the date provision limiting application of the above provision to ALF facilities existing as of January 1, 1996.

B. SECTION DIRECTORY:

Section 1: amends s. 429.41, F.S., relating to rules establishing standards for firesafety.

Section 2: provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues: None.

2. Expenditures: None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues: None.

2. Expenditures: None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Under the bill, ALFs will be able to build and add improvements to new and existing structures in accordance with the current Life Safety Code.

D. FISCAL COMMENTS: None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

[6] The Department of Financial Services, Agency Analysis of 2015 House Bill 965, p. 2 (Dec. 22, 2015).
[7] Email from Susan E. Anderson, Vice President of Public Policy, Florida Assisted Living Federation of America, RE: HB Florida Insurance & Banking Subcommittee -- House Bill 965 Inquiry (Jan. 29, 2016).

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

B. RULE-MAKING AUTHORITY: None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Lines 25-27 state that the Department of Financial Services shall adopt uniform firesafety standards as specified in s. 633.206, F.S. This language appears to be redundant with ss. 633.206(1)(b) and 633.202(2), F.S.

Lines 51-53 state than an evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure. It is not clear what entity is responsible for conducting this evaluation. Additionally, it is not clear under what standard the evacuation capability evaluation should be conducted.

Lines 140-145 state "a utility" may charge fees not in excess of the actual expense incurred in the installation and maintenance of an automatic fire sprinkler system in an ALF. It is unclear what type of entity "a utility" refers to and who this provision applies to.

Lines 140-145 also state that "a utility," in addition to "a local government," are the entities prohibited from charging in excess of the actual expense incurred in the installation and maintenance of an automatic fire sprinkler system. The provision limiting application of the above provision to ALF facilities "existing" as of January 1, 1996, is removed. As a result, it becomes unclear as to what point in time an ALF has to "exist" for this provision to be applicable.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to firesafety; amending s. 429.41,
3 F.S.; requiring the State Fire Marshal to adopt
4 uniform firesafety standards for assisted living
5 facilities; revising provisions relating to the
6 minimum standards that must be adopted by the
7 Department of Elderly Affairs for firesafety in
8 assisted living facilities; providing an effective
9 date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Subsection (1) of section 429.41, Florida
14 Statutes, are amended to read:
15 429.41 Rules establishing standards.—
16 (1) It is the intent of the Legislature that rules
17 published and enforced pursuant to this section shall include
18 criteria by which a reasonable and consistent quality of
19 resident care and quality of life may be ensured and the results
20 of such resident care may be demonstrated. Such rules shall also
21 ensure a safe and sanitary environment that is residential and
22 noninstitutional in design or nature. It is further intended
23 that reasonable efforts be made to accommodate the needs and
24 preferences of residents to enhance the quality of life in a
25 facility. <u>The State Fire Marshal shall adopt uniform firesafety</u>
26 <u>standards for assisted living facilities as specified in s.</u>

27 633.206. The agency, in consultation with the department, may
28 adopt rules to administer the requirements of part II of chapter
29 408. In order to provide safe and sanitary facilities and the
30 highest quality of resident care accommodating the needs and
31 preferences of residents, the department, in consultation with
32 the agency, the Department of Children and Families, and the
33 Department of Health, shall adopt rules, policies, and
34 procedures to administer this part, which must include
35 reasonable and fair minimum standards in relation to:
36 (a) The requirements for and maintenance of facilities,
37 not in conflict with chapter 553, relating to plumbing, heating,
38 cooling, lighting, ventilation, living space, and other housing
39 conditions, which will ensure the health, safety, and comfort of
40 residents ~~and protection from fire hazard, including adequate~~
41 ~~provisions for fire alarm and other fire protection~~ suitable to
42 the size of the structure. ~~Uniform firesafety standards shall be~~
43 ~~established and enforced by the State Fire Marshal in~~
44 ~~cooperation with the agency, the department, and the Department~~
45 ~~of Health.~~
46 1. Firesafety evacuation capability determination.—
47 ~~a. The National Fire Protection Association, NFPA 101A,~~
48 ~~Chapter 5, 1995 edition, shall be used for determining the~~
49 ~~ability of the residents, with or without staff assistance, to~~
50 ~~relocate from or within a licensed facility to a point of safety~~
51 ~~as provided in the fire codes adopted herein.~~ An evacuation
52 capability evaluation for initial licensure shall be conducted

53 within 6 months after the date of licensure. ~~For existing~~
54 ~~licensed facilities that are not equipped with an automatic fire~~
55 ~~sprinkler system, the administrator shall evaluate the~~
56 ~~evacuation capability of residents at least annually. The~~
57 ~~evacuation capability evaluation for each facility not equipped~~
58 ~~with an automatic fire sprinkler system shall be validated,~~
59 ~~without liability, by the State Fire Marshal, by the local fire~~
60 ~~marshal, or by the local authority having jurisdiction over~~
61 ~~firesafety, before the license renewal date. If the State Fire~~
62 ~~Marshal, local fire marshal, or local authority having~~
63 ~~jurisdiction over firesafety has reason to believe that the~~
64 ~~evacuation capability of a facility as reported by the~~
65 ~~administrator may have changed, it may, with assistance from the~~
66 ~~facility administrator, reevaluate the evacuation capability~~
67 ~~through timed exiting drills. Translation of timed fire exiting~~
68 ~~drills to evacuation capability may be determined:~~
69 ~~(I) Three minutes or less: prompt.~~
70 ~~(II) More than 3 minutes, but not more than 13 minutes:~~
71 ~~slow.~~
72 ~~(III) More than 13 minutes: impractical.~~
73 ~~b. The Office of the State Fire Marshal shall provide or~~
74 ~~cause the provision of training and education on the proper~~
75 ~~application of Chapter 5, NFPA 101A, 1995 edition, to its~~
76 ~~employees, to staff of the Agency for Health Care Administration~~
77 ~~who are responsible for regulating facilities under this part,~~
78 ~~and to local governmental inspectors. The Office of the State~~

79 ~~Fire Marshal shall provide or cause the provision of this~~
80 ~~training within its existing budget, but may charge a fee for~~
81 ~~this training to offset its costs. The initial training must be~~
82 ~~delivered within 6 months after July 1, 1995, and as needed~~
83 ~~thereafter.~~
84 ~~c. The Office of the State Fire Marshal, in cooperation~~
85 ~~with provider associations, shall provide or cause the provision~~
86 ~~of a training program designed to inform facility operators on~~
87 ~~how to properly review bid documents relating to the~~
88 ~~installation of automatic fire sprinklers. The Office of the~~
89 ~~State Fire Marshal shall provide or cause the provision of this~~
90 ~~training within its existing budget, but may charge a fee for~~
91 ~~this training to offset its costs. The initial training must be~~
92 ~~delivered within 6 months after July 1, 1995, and as needed~~
93 ~~thereafter.~~
94 ~~d. The administrator of a licensed facility shall sign an~~
95 ~~affidavit verifying the number of residents occupying the~~
96 ~~facility at the time of the evacuation capability evaluation.~~
97 2. Firesafety requirements.—
98 a. ~~Except for the special applications provided herein,~~
99 ~~effective January 1, 1996,~~ The National Fire Protection
100 Association, Life Safety Code, NFPA 101 and 101A, current
101 editions ~~1994 edition~~, ~~Chapter 22 for new facilities and Chapter~~
102 ~~23 for existing facilities~~ shall be used in determining the
103 uniform firesafety ~~fire~~ code adopted ~~applied~~ by the State Fire
104 Marshal for assisted living facilities, pursuant to s. 633.206.

105 ~~b. Any new facility, regardless of size, that applies for~~
106 ~~a license on or after January 1, 1996, must be equipped with an~~
107 ~~automatic fire sprinkler system. The exceptions as provided in~~
108 ~~s. 22-2.3.5.1, NFPA 101, 1994 edition, as adopted herein, apply~~
109 ~~to any new facility housing eight or fewer residents. On July 1,~~
110 ~~1995, local governmental entities responsible for the issuance~~
111 ~~of permits for construction shall inform, without liability, any~~
112 ~~facility whose permit for construction is obtained before~~
113 ~~January 1, 1996, of this automatic fire sprinkler requirement.~~
114 ~~As used in this part, the term "a new facility" does not mean an~~
115 ~~existing facility that has undergone change of ownership.~~
116 ~~c. Notwithstanding any provision of s. 633.206 or of the~~
117 ~~National Fire Protection Association, NFPA 101A, Chapter 5, 1995~~
118 ~~edition, to the contrary, any existing facility housing eight or~~
119 ~~fewer residents is not required to install an automatic fire~~
120 ~~sprinkler system, nor to comply with any other requirement in~~
121 ~~Chapter 23, NFPA 101, 1994 edition, that exceeds the firesafety~~
122 ~~requirements of NFPA 101, 1988 edition, that applies to this~~
123 ~~size facility, unless the facility has been classified as~~
124 ~~impractical to evacuate. Any existing facility housing eight or~~
125 ~~fewer residents that is classified as impractical to evacuate~~
126 ~~must install an automatic fire sprinkler system within the~~
127 ~~timeframes granted in this section.~~
128 ~~d. Any existing facility that is required to install an~~
129 ~~automatic fire sprinkler system under this paragraph need not~~
130 ~~meet other firesafety requirements of Chapter 23, NFPA 101, 1994~~

131 ~~edition, which exceed the provisions of NFPA 101, 1988 edition.~~
132 ~~The mandate contained in this paragraph which requires certain~~
133 ~~facilities to install an automatic fire sprinkler system~~
134 ~~supersedes any other requirement.~~
135 ~~e. This paragraph does not supersede the exceptions~~
136 ~~granted in NFPA 101, 1988 edition or 1994 edition.~~
137 ~~f. This paragraph does not exempt facilities from other~~
138 ~~firesafety provisions adopted under s. 633.206 and local~~
139 ~~building code requirements in effect before July 1, 1995.~~
140 b.~~g.~~ A local government or a utility may charge fees only
141 in an amount not to exceed the actual expenses incurred by the
142 local government or the utility relating to the installation and
143 maintenance of an automatic fire sprinkler system in an existing
144 and properly licensed assisted living facility structure ~~as of~~
145 ~~January 1, 1996~~.
146 ~~h. If a licensed facility undergoes major reconstruction~~
147 ~~or addition to an existing building on or after January 1, 1996,~~
148 ~~the entire building must be equipped with an automatic fire~~
149 ~~sprinkler system. Major reconstruction of a building means~~
150 ~~repair or restoration that costs in excess of 50 percent of the~~
151 ~~value of the building as reported on the tax rolls, excluding~~
152 ~~land, before reconstruction. Multiple reconstruction projects~~
153 ~~within a 5-year period the total costs of which exceed 50~~
154 ~~percent of the initial value of the building when the first~~
155 ~~reconstruction project was permitted are to be considered as~~
156 ~~major reconstruction. Application for a permit for an automatic~~

157 ~~fire sprinkler system is required upon application for a permit~~
158 ~~for a reconstruction project that creates costs that go over the~~
159 ~~50-percent threshold.~~
160 ~~i. Any facility licensed before January 1, 1996, that is~~
161 ~~required to install an automatic fire sprinkler system shall~~
162 ~~ensure that the installation is completed within the following~~
163 ~~timeframes based upon evacuation capability of the facility as~~
164 ~~determined under subparagraph 1.:~~
165 ~~(I) Impractical evacuation capability, 24 months.~~
166 ~~(II) Slow evacuation capability, 48 months.~~
167 ~~(III) Prompt evacuation capability, 60 months.~~
168
169 ~~The beginning date from which the deadline for the automatic~~
170 ~~fire sprinkler installation requirement must be calculated is~~
171 ~~upon receipt of written notice from the local fire official that~~
172 ~~an automatic fire sprinkler system must be installed. The local~~
173 ~~fire official shall send a copy of the document indicating the~~
174 ~~requirement of a fire sprinkler system to the Agency for Health~~
175 ~~Care Administration.~~
176 ~~j. It is recognized that the installation of an automatic~~
177 ~~fire sprinkler system may create financial hardship for some~~
178 ~~facilities. The appropriate local fire official shall, without~~
179 ~~liability, grant two 1-year extensions to the timeframes for~~
180 ~~installation established herein, if an automatic fire sprinkler~~
181 ~~installation cost estimate and proof of denial from two~~
182 ~~financial institutions for a construction loan to install the~~

183 ~~automatic fire sprinkler system are submitted. However, for any~~
184 ~~facility with a class I or class II, or a history of uncorrected~~
185 ~~class III, firesafety deficiencies, an extension must not be~~
186 ~~granted. The local fire official shall send a copy of the~~
187 ~~document granting the time extension to the Agency for Health~~
188 ~~Care Administration.~~
189 ~~k. A facility owner whose facility is required to be~~
190 ~~equipped with an automatic fire sprinkler system under Chapter~~
191 ~~23, NFPA 101, 1994 edition, as adopted herein, must disclose to~~
192 ~~any potential buyer of the facility that an installation of an~~
193 ~~automatic fire sprinkler requirement exists. The sale of the~~
194 ~~facility does not alter the timeframe for the installation of~~
195 ~~the automatic fire sprinkler system.~~
196 ~~l. Existing facilities required to install an automatic~~
197 ~~fire sprinkler system as a result of construction-type~~
198 ~~restrictions in Chapter 23, NFPA 101, 1994 edition, as adopted~~
199 ~~herein, or evacuation capability requirements shall be notified~~
200 ~~by the local fire official in writing of the automatic fire~~
201 ~~sprinkler requirement, as well as the appropriate date for final~~
202 ~~compliance as provided in this subparagraph. The local fire~~
203 ~~official shall send a copy of the document to the Agency for~~
204 ~~Health Care Administration.~~
205 ~~m. Except in cases of life-threatening fire hazards, if an~~
206 ~~existing facility experiences a change in the evacuation~~
207 ~~capability, or if the local authority having jurisdiction~~
208 ~~identifies a construction-type restriction, such that an~~

209 ~~automatic fire sprinkler system is required, it shall be given~~
210 ~~time for installation as provided in this subparagraph.~~
211
212 ~~Facilities that are fully sprinkled and in compliance with other~~
213 ~~firesafety standards are not required to conduct more than one~~
214 ~~of the required fire drills between the hours of 11 p.m. and 7~~
215 ~~a.m., per year. In lieu of the remaining drills, staff~~
216 ~~responsible for residents during such hours may be required to~~
217 ~~participate in a mock drill that includes a review of evacuation~~
218 ~~procedures. Such standards must be included or referenced in the~~
219 ~~rules adopted by the State Fire Marshal. Pursuant to s.~~
220 ~~633.206(1)(b), the State Fire Marshal is the final~~
221 ~~administrative authority for firesafety standards established~~
222 ~~and enforced pursuant to this section.~~
223 c. All licensed facilities must have an annual fire
224 inspection conducted by the local fire marshal or authority
225 having jurisdiction.
226 3. Resident elopement requirements.—Facilities are
227 required to conduct a minimum of two resident elopement
228 prevention and response drills per year. All administrators and
229 direct care staff must participate in the drills which shall
230 include a review of procedures to address resident elopement.
231 Facilities must document the implementation of the drills and
232 ensure that the drills are conducted in a manner consistent with
233 the facility's resident elopement policies and procedures.
234 (b) The preparation and annual update of a comprehensive

235 emergency management plan. Such standards must be included in
236 the rules adopted by the department after consultation with the
237 Division of Emergency Management. At a minimum, the rules must
238 provide for plan components that address emergency evacuation
239 transportation; adequate sheltering arrangements; postdisaster
240 activities, including provision of emergency power, food, and
241 water; postdisaster transportation; supplies; staffing;
242 emergency equipment; individual identification of residents and
243 transfer of records; communication with families; and responses
244 to family inquiries. The comprehensive emergency management plan
245 is subject to review and approval by the local emergency
246 management agency. During its review, the local emergency
247 management agency shall ensure that the following agencies, at a
248 minimum, are given the opportunity to review the plan: the
249 Department of Elderly Affairs, the Department of Health, the
250 Agency for Health Care Administration, and the Division of
251 Emergency Management. Also, appropriate volunteer organizations
252 must be given the opportunity to review the plan. The local
253 emergency management agency shall complete its review within 60
254 days and either approve the plan or advise the facility of
255 necessary revisions.
256 (c) The number, training, and qualifications of all
257 personnel having responsibility for the care of residents. The
258 rules must require adequate staff to provide for the safety of
259 all residents. Facilities licensed for 17 or more residents are
260 required to maintain an alert staff for 24 hours per day.

261 (d) All sanitary conditions within the facility and its
262 surroundings which will ensure the health and comfort of
263 residents. The rules must clearly delineate the responsibilities
264 of the agency's licensure and survey staff, the county health
265 departments, and the local authority having jurisdiction over
266 firesafety and ensure that inspections are not duplicative. The
267 agency may collect fees for food service inspections conducted
268 by the county health departments and transfer such fees to the
269 Department of Health.
270 (e) License application and license renewal, transfer of
271 ownership, proper management of resident funds and personal
272 property, surety bonds, resident contracts, refund policies,
273 financial ability to operate, and facility and staff records.
274 (f) Inspections, complaint investigations, moratoriums,
275 classification of deficiencies, levying and enforcement of
276 penalties, and use of income from fees and fines.
277 (g) The enforcement of the resident bill of rights
278 specified in s. 429.28.
279 (h) The care and maintenance of residents, which must
280 include, but is not limited to:
281 1. The supervision of residents;
282 2. The provision of personal services;
283 3. The provision of, or arrangement for, social and
284 leisure activities;
285 4. The arrangement for appointments and transportation to
286 appropriate medical, dental, nursing, or mental health services,

287 as needed by residents;
288 5. The management of medication;
289 6. The nutritional needs of residents;
290 7. Resident records; and
291 8. Internal risk management and quality assurance.
292 (i) Facilities holding a limited nursing, extended
293 congregate care, or limited mental health license.
294 (j) The establishment of specific criteria to define
295 appropriateness of resident admission and continued residency in
296 a facility holding a standard, limited nursing, extended
297 congregate care, and limited mental health license.
298 (k) The use of physical or chemical restraints. The use of
299 physical restraints is limited to half-bed rails as prescribed
300 and documented by the resident's physician with the consent of
301 the resident or, if applicable, the resident's representative or
302 designee or the resident's surrogate, guardian, or attorney in
303 fact. The use of chemical restraints is limited to prescribed
304 dosages of medications authorized by the resident's physician
305 and must be consistent with the resident's diagnosis. Residents
306 who are receiving medications that can serve as chemical
307 restraints must be evaluated by their physician at least
308 annually to assess:
309 1. The continued need for the medication.
310 2. The level of the medication in the resident's blood.
311 3. The need for adjustments in the prescription.
312 (l) The establishment of specific policies and procedures

313 on resident elopement. Facilities shall conduct a minimum of two
314 resident elopement drills each year. All administrators and
315 direct care staff shall participate in the drills. Facilities
316 shall document the drills.
317 Section 2. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1317 Interstate Purchase of Health Insurance
SPONSOR(S): Miller
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Peterson KP	Luczynski MY
2) Appropriations Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill allows any insurer authorized to engage in the sale of health insurance in any state, district, territory, or commonwealth of the United States, other than Florida, to sell individual health insurance in this state. An insurer selling such insurance is exempted from the provisions of the Florida Insurance Code, but must meet the following requirements:

- The insurer must have a valid certificate of authority to engage in the sale of individual health insurance in the state under which laws the insurer was formed, known as the insurer's domicile.
- A health insurance product offered for sale must comply with all applicable laws of the insurer's domicile.
- A health insurance product offered for sale in Florida must also be offered for sale in the insurer's domicile.
- An application for individual health insurance and the insurance product itself must include a conspicuous, boldfaced disclosure statement, in at least 12-point font, which informs the consumer that:
  - The health insurance product is being offered by an insurer based in another state;
  - The product is subject to the laws of that state; and
  - The product is not subject to the insurance laws of Florida, including state-mandated benefits.
- The disclosure statement must advise the consumer to review the terms and conditions of the insurance product carefully, including exclusions and coverage limitations, and advise the consumer to consult his or her insurance agent to determine the Florida state-mandated benefits that are excluded under the product.
- The insurer must establish a grievance procedure for residents of Florida who purchase health insurance policies under this section.

The bill also requires each foreign insurer selling health insurance to annually report to the Office of Insurance Regulation (OIR) the following information:

- The foreign insurer's state of domicile.
- The number of individual health insurance products sold.
- Each county where at least one such individual health insurance product was sold.
- The number of persons covered by such individual health insurance products.
- The total premium collected on such individual health insurance products.

The OIR is required to post the report from each foreign insurer to its website.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Insurance Regulation in Florida

Insurance products are regulated under chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S., collectively referred to as the Florida Insurance Code, by the Office of Insurance Regulation (OIR). Health insurance products are specifically regulated under the following chapters:

- Chapter 627, F.S.
  - Part VI - Health Insurance Policies
  - Part VII - Group, Blanket, and Franchise Health Insurance Policies
  - Part VIII - Medicare Supplement Policies
- Chapter 631, F.S.
  - Part III - Life and Health Insurance Guaranty of Payments
  - Part IV - Health Maintenance Organization Consumer Assistance Plan
- Chapter 636, F.S.
  - Part I - Prepaid Limited Health Service Organizations
  - Part II - Discount Medical Plan Organizations
- Chapter 641, F.S.
  - Part I - Health Maintenance Organizations
  - Part II - Prepaid Health Clinics
  - Part III - Health Care Services
- Chapter 651, F.S. - Continuing Care Contracts

The OIR is responsible for regulating all insurers and other risk bearing entities doing business in the state. These responsibilities include authorizing domestic, foreign, and alien insurers to transact insurance in the state; the review of company rate and form filings across regulated lines of insurance; monitoring the financial strength, solvency, and risk of insurance companies; and ensuring that insurance contract provisions remain current with legal and market conditions.

Interstate Purchase of Health Insurance - Federal Efforts

In general, states regulate the business of insurance within their borders.[1] The federal government in recent years has enacted or proposed laws that create frameworks for specific types of health insurance product to be sold across state lines.

Multi-State Plans

Section 1334 of the Patient Protection and Affordable Care Act (PPACA)[2] established the Multi-State Plan (MSP) Program, which directs the federal Office of Personnel Management (OPM)[3] to contract

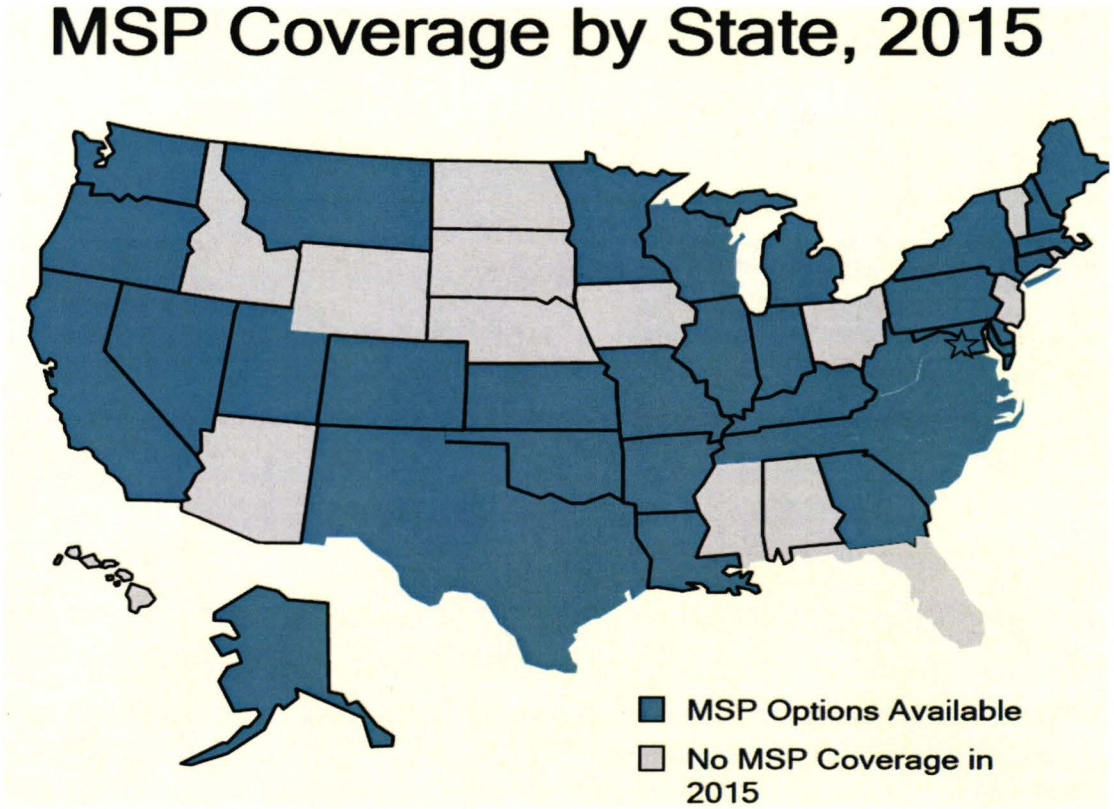
[1] The Patient Protection and Affordable Care Act (PPACA) imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, covering adult dependents, internal and external appeals of adverse benefit determinations, and other requirements. These requirements preempt any state insurance provisions that prevent the implementation of PPACA and expand federal regulation of health insurance within states' borders.

[2] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148. On March 30, 2010, PPACA was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

[3] Formerly the responsibility of the now-defunct Civil Service Commission, the OPM is responsible for personnel management of the civil service of the federal government. The OPM also administers the health plan for federal government employees, the Federal Employees Health Benefits program.

with private health insurers in each state to offer at least two multi-state qualified health plans through the Health Insurance Marketplace in each state.[4] MSP options are available to individuals and small businesses.[5] MSPs offer coverage for essential health benefits and offer bronze, silver, and gold levels of coverage, in addition to catastrophic coverage.[6]

In the 2014 plan year, the OPM contracted with the Blue Cross and Blue Shield Association (BCBS) to offer more than 150 MSP options in 31 states, including the District of Columbia.[7] Approximately 371,000 individuals enrolled in an MSP option for the 2014 plan year.[8] For the 2015 plan year, the OPM contracted with the BCBS and a group of CO-OPs[9] to offer more than 200 MSPs in 36 states and the District of Columbia.[10] There were approximately 450,000 MSP enrollees for the 2015 plan year.[11] The map below shows the availability of MSPs for the 2015 plan year.[12]



PPACA requires MSPs to extend coverage offerings to all 50 states by 2017.[13]

Interstate Health Compacts

PPACA permits a state to enter into an agreement, called a "health care choice compact," with one or more other states to offer health insurance plans across state lines, subject to approval of the Secretary

[4] 42 U.S.C. §18054(a)(1).
[5] *Id.*
[6] 42 U.S.C. § 18054(c)(1)(A) and (B).
[7] U.S. Office of Personnel Management, National Healthcare Operations, Healthcare & Insurance, *An Overview of the Multi-State Plan Program,* slide 7 (on file with the House Insurance & Banking Subcommittee).
[8] *Id.*
[9] PPACA established the Consumer Operated and Oriented Plan (CO-OP) Program, which facilitated the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets. For more information on CO-OPs, *see* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Insurance-Programs/Consumer-Operated-and-Oriented-Plan-Program.html.
[10] *Supra* note 7, at slide 9.
[11] *Id.*
[12] *Id.* at slide 8.
[13] 42 U.S.C. § 18054(e).

of the federal Department of Health and Human Services.[14] States must pass a law allowing their participation in a compact.[15]

Interstate plans offered through the compact are subject to the market conduct rules, network adequacy requirements, unfair trade standards, and consumer protection requirements of the state where the purchaser of the plan resides.[16] Insurers are required to be licensed in all states participating in the compact and to file plan forms for review in each state in which a plan will be offered through the compact.[17] Also, insurers must clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's state.[18]

PPACA required the Secretary of the federal Department of Health and Human Services, in consultation with National Association of Insurance Commissioners, to issue regulations for interstate health care choice compacts, which can be entered into beginning in 2016.[19] However, no regulations have been issued to date.

Health Care Choice Act of 2015

The Health Care Choice Act of 2015 (Act), filed in the U.S. House of Representatives by Rep. Blackburn (TN) and in the U.S. Senate by Sen. Cruz (TX) includes, among other provisions, an amendment to the Public Health Service Act[20] to provide for the interstate purchase of health insurance.[21] The Act would allow a health insurance company to designate a "primary state," the laws of which would apply to individual health insurance offered by that company in the primary state and in any other state, known as "secondary states."[22] A health insurance company would be exempt from any law of a secondary state prohibiting or regulating the company's operations in that state.[23] The primary state would have jurisdiction over enforcing its own laws on a health insurance company in both the primary and secondary states.[24]

The Act was referred to committees in both the House and Senate in April 2015. No further has action occurred since that time.

Interstate Purchase of Health Insurance - State Efforts

Several states have enacted laws permitting the sale of health insurance across state lines, or providing for a study of the sale of health insurance across state lines. Kentucky, Rhode Island, and Washington passed laws directed at researching and evaluating the feasibility of allowing the sale of policies across state lines or forming interstate compacts. Georgia, Maine, and Wyoming passed laws that permit, to varying degrees, the interstate sale of health insurance.

Georgia

In 2011, Georgia passed a law requiring the state insurance commissioner to approve individual health policies for sale in the state by a Georgia-licensed insurer if the policies were approved in other states.[25] The insurance commissioner promulgated regulations to implement the law, providing insurers

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[14] PPACA §§1333(a) and 1331(b)(3)(B). PPACA also authorizes states to negotiate regional compacts with other states to cover low income individuals not eligible for Medicaid in "standardized health plans."
[15] PPACA § 1333(a)(2).
[16] PPACA § 1333(a)(1)(B)(i).
[17] PPACA § 1333(a)(1)(B)(ii).
[18] PPACA § 1333(a)(1)(B)(iii).
[19] PPACA § 1333(a)(1).
[20] 42 U.S.C. § 300gg et seq.
[21] Health Care Choice Act of 2015, H.R. 543, 114th Cong. §3 (2015).
[22] *Id.* at § 5.
[23] *Id.*
[24] *Id.*
[25] Official Code of Ga. Ann. § 33-29A-30 et. seq.

with operational guidance and filing requirements.[26] To date, no insurer has sought approval to sell out-of-state individual health policies in Georgia.

Maine

In 2011, Maine passed a law, similar to Georgia's law, which expressly exempts certain insurers from the state's health insurance licensing process and allows those insurers to sell out-of-state individual health policies in Maine.[27] The law requires the insurers to be licensed to sell individual market health insurance in Connecticut, Massachusetts, New Hampshire, or Rhode Island.[28] The law became effective January 1, 2014. Since that time, there has been no interest from insurers in selling out-of-state policies in Maine pursuant to this law.

Wyoming

Wyoming law allows out-of-state insurers to offer their health insurance plans in the state if the state where the insurer is licensed has insurance regulations that are consistent with those of Wyoming.[29] Since the law passed, Wyoming officials reported a lack of interest from insurers with no inquiries about selling out-of-state policies in the state.[30]

Kentucky

Kentucky's legislation did not require the state to conduct a study, but instead expressed the state's intent to "explore the feasibility" of entering into an interstate reciprocal health benefit plan compact with contiguous states.[31] The insurance commissioner sent letters to the insurance commissioners of Kentucky's seven contiguous states – Missouri, Illinois, Indiana, Ohio, West Virginia, Virginia, and Tennessee – to determine interest in joining in a compact.[32] After discussions with these states, officials concluded that there were significant roadblocks to the implementation of a compact.[33] Kentucky has taken no further action regarding the interstate purchase of health insurance.

Rhode Island

In 2008, the Rhode Island General Assembly passed Senate Bill 2286, Substitute B, requiring the health insurance commissioner to submit a report, by March 1, 2009, identifying what legislative and regulatory changes were necessary to allow health insurers licensed in other New England states to do business in Rhode Island without further licensure by the state.[34] The intent of the law was to establish a regional health insurance market, and the report was the first step in determining if such a regional market was feasible.

The report was not completed. State officials indicated stakeholders had expressed no interest in the option.[35] In fact, a regional health insurer based in Massachusetts indicated only minimal interest in the legislation, noting that Rhode Island's regulatory requirements were a low priority in deciding whether to enter the market.[36] To date, Rhode Island officials have not been contacted by any insurer about the issue and have taken no further action.

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[26] Ga. Admin. Code § 120-2-99-.01 et. seq.
[27] Me. Rev. Stat. Ann. tit. 24-A, §405-A (2011).
[28] *Id.* at §405-A(1.).
[29] Wyo. Stat. Ann. §26-18-302(a).
[30] *Supra note* 25, at 10.
[31] 2012 Ky. Acts, 166, §10.
[32] Corlette, S., Monahan, C., et al., *Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage*, Georgetown University Health Policy Institute-The Center on Health Insurance Reforms, Oct. 2012, at 7, *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401409 (last visited Jan. 28, 2016).
[33] *Id.*
[34] R.I. Gen. Laws §27-67-4 (2008).
[35] *Supra* note 32.
[36] *Id.*

Washington

The Washington state Department of Insurance was required to complete a feasibility study, which was submitted to the legislature in 2008.[37] The study concluded that a multi-state compact for the regulation of health insurance was not viable. Specifically, the study noted that:

- There was not sufficient consensus among states to make a health insurance compact feasible, primarily due to the varying approaches to health insurance regulation.
- A compact would require leveling the diversity in costs of health care goods and services that exist in each state and in various markets within each state and, because health care costs are impacted by local issues like the availability of providers and population demographics, a compact could not accomplish the leveling of prices.[38]

The study also concludes that the administrative costs needed to create a compact outweigh the potential benefits of the compact.[39]

Florida Health Insurance Mandates

A mandate is usually defined as required health coverage for specific types of treatments, benefits, providers, or categories of dependents.[40] In Florida, health insurance coverage mandates are found throughout the insurance code, depending on the coverage type and insurance product. In addition, some types of health insurance coverage are exempt from state mandates, such as self-funded or ERISA plans. Florida has at least 52 different mandates across the small group, individual, or large group health insurance market, including health maintenance organizations.

Effect of Proposed Changes

The bill creates s. 627.6325, F.S., which allows any insurer authorized to engage in the sale of health insurance in any state, district, territory, or commonwealth of the United States, other than Florida (foreign insurer), to sell individual health insurance in this state. Foreign insurers are limited to selling major medical insurance under the provisions of the bill. Individual health insurance, for the purposes of the bill, does not include products such as dental, vision, long-term care, or other supplemental insurance.

An insurer selling such products in the state is exempted from the provisions of the Florida Insurance Code,[41] including rate and form reviews by the OIR, solvency and risk requirements, and all other state regulations, but must meet the following requirements:

- The insurer must have a valid certificate of authority to engage in the sale of individual health insurance in the state under which laws the insurer was formed, known as the insurer's domicile.[42]
- A health insurance product offered for sale under s. 627.6325, F.S., must comply with all applicable laws of the insurer's domicile.

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[37] Washington State Office of the Insurance Commissioner, *Feasibility Study on the Use of an Interstate Compact to Provide Individual Health Insurance*, Dec. 1, 2008, *available* at http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0ahUKEwixvOLbls3KAhVFXR4KHZUOBaAQFggoMAI&url=http%3A%2F%2Fapp.leg.wa.gov%2FReportsToTheLegislature%2FHome%2FGetPDF%3FfileName%3DLegRptFeasibility_0f86beac-e345-456b-b8d6-81ad5b341e85.pdf&usg=AFQjCNF-RnG0_Cb_RUg6Nqn9dNwYTmwBcw&sig2=xzm4XmIX_mrc72xrB8N2pw&bvm=bv.112766941,d.dmo (last visited Jan. 28, 2016).

[38] *Supra* note 32, at pg. 8.

[39] *Id.*

[40] NATIONAL CONFERENCE OF STATE LEGISLATURES, *Mandated Health Insurance Benefits and State Laws* (last updated Jan. 2014) http://www.ncsl.org/issues-research/health/mandated-health-insurance-benefits-and-state-laws.aspx (last visited Jan. 28, 2016).

[41] s. 624.01, F.S.

[42] s. 624.07(4), F.S.

- A health insurance product offered for sale must be offered for sale in the insurer's domicile.
- An application for health insurance and the health insurance product itself must include a conspicuous, boldfaced disclosure statement, in at least 12-point font, which informs the consumer that:
  - The health insurance product is being offered by an insurer based in another state;
  - The product is subject to the laws of that state; and
  - The product is not subject to any insurance laws of Florida, including state-mandated benefits.
- The disclosure statement must advise the consumer to review the terms and conditions of the product carefully, including exclusions and coverage limitations, and advise the consumer to consult his or her insurance agent to determine the Florida state-mandated benefits that are excluded.
- The insurer must establish a grievance procedure for residents of Florida who purchase health insurance products under this section.

The bill also requires each foreign insurer selling health insurance pursuant to s. 627.6325, F.S., to annually report to the OIR the following information:

- The foreign insurer's state of domicile.
- The number of individual health insurance products sold.
- Each county where at least one such individual health insurance product was sold.
- The number of persons covered by such individual health insurance products.
- The total premium collected on such individual health insurance products.

The OIR is required to post the report from each foreign insurer to its website.

The bill may provide consumers with more options for health coverage that fit their individual needs. The products that may be offered under these provisions will not be required to include all of the health benefits and services mandated in Florida law. In addition, foreign insurers will not be subject to the same administrative requirements as authorized insurers. As a result, premiums for these plans may be lower, thereby benefiting consumers, but potentially harming admitted carriers who are subject to all of Florida's licensing requirements and mandated benefits.

The bill provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1: Creates s. 627.6235, F.S., relating to interstate purchase of individual health insurance.
Section 2: Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill provides that unlicensed foreign insurers are not subject to any insurance laws or rules of Florida. As such, these insurers would not be subject to Florida laws that require the payment of premium taxes, filing fees, or assessments. The reduction in premium taxes, fees, or fines is unknown and would depend on the number of insurers choosing to operate as an unlicensed foreign insurer.[43]

2. Expenditures:

[43] Florida Office of Insurance Regulation, Agency Analysis of 2016 House Bill 1317, p. 3 (Jan. 27, 2016).

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Florida consumers may be able to choose from a wider array of health insurance products that fit their individual needs for coverage without including coverage for products that they will not use, thereby lowering the cost of insurance coverage to the individual. However, it is uncertain how the federal government will treat health insurance products sold to Florida citizens that do not meet Florida benchmark requirements, even though such products are authorized for sale in another state under that state's benchmark requirements.

Foreign insurers would not be required to include any of Florida's statutorily required health benefits nor would the premium for those policies be subject to any regulatory approval. Insurers licensed in Florida would still be required to comply with Florida's mandated health benefit statutes and other provisions of Florida law and, as a result, would be put at a competitive disadvantage.[44]

Florida's solvency laws would not apply to foreign insurers. Thus, the OIR would have no ability to oversee solvency or financial regulation. As a result, consumers may be at risk of financial harm from foreign insurers domiciled in states with low capital and surplus requirements. These insurers do not meet the definition of "member insurer" for purposes of inclusion in the Florida Life and Health Insurance Guaranty Association Act. As a result, if one of these foreign insurers were to become insolvent, the fund would not be available to compensate consumers or practitioners with claims owed.[45]

The bill allows foreign insurers to sell policies within the state that are not subject to state regulation. While this limits administrative requirements that may be adding to the cost of health insurance sold in Florida, it eliminates consumer protections that are part of Florida's licensing law. Foreign insurers would be required to have a grievance procedure to address consumer concerns, however, the Division of Consumer Services within the Department of Financial Services would not have authority to act on any complaint.[46]

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

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[44] *Id.* at 5.
[45] *Id.*
[46] *Id.*

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable. The adoption of rules is not necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The notice requirement directs consumers to contact their insurance agent to determine what state-mandated benefits may be omitted in a policy sold by a foreign insurer. The OIR notes that insurance agents are prohibited under Florida law from marketing policies for unlicensed insurers. The OIR further questions whether an agent would know all of Florida's mandated coverages and, as a result, be able to identify those that are not part of a policy sold by a foreign insurer.[47]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[47] *Id.*

1 A bill to be entitled
2 An act relating to interstate purchase of health
3 insurance; creating s. 627.6325, F.S.; allowing a
4 foreign insurer to offer individual health insurance
5 for sale in this state upon meeting certain
6 requirements; establishing requirements; exempting a
7 foreign insurer from the Florida Insurance Code;
8 providing an effective date.
9
10 Be It Enacted by the Legislature of the State of Florida:
11
12 Section 1. Section 627.6325, Florida Statutes, is created
13 to read:
14 627.6325 Interstate purchase of individual health
15 insurance.—Notwithstanding any provision of the Florida
16 Insurance Code, a foreign insurer authorized to transact
17 individual health insurance in any state may offer for sale in
18 this state individual health insurance as defined in s. 627.6487
19 if the following requirements are met:
20 (1) The foreign insurer holds a valid certificate of
21 authority to transact individual health insurance in its
22 domicile.
23 (2) Individual health insurance offered for sale under
24 this section complies with all applicable laws of the domicile
25 of the foreign insurer and is offered for sale in such domicile.
26 (3) The foreign insurer files an annual report in the

27 format prescribed by the office. The office must post the report
28 on its website. The report must include:
29 (a) The state of domicile.
30 (b) The total number of individual health insurance
31 products sold in this state under this section.
32 (c) A list of counties in which the foreign insurer sold
33 its individual health insurance products under this section.
34 (d) The number of individuals covered by such individual
35 health insurance products.
36 (e) The total premium collected by the foreign insurer on
37 individual health insurance products sold in this state under
38 this section.
39 (4) An application for individual health insurance and the
40 individual health insurance issued under this section each
41 contain the following statement in at least 12-point
42 conspicuous, boldfaced type:
43
44 This ...(name of health insurance product)... is issued by
45 a foreign insurer and is governed by the laws and rules of
46 ...(domicile of foreign insurer).... This ...(name of
47 health insurance product)... is not subject to any
48 insurance laws or rules of Florida, including state-
49 mandated health benefits. Before purchasing this ...(name
50 of health insurance product)..., you should carefully
51 review the terms and conditions of coverage, including any
52 exclusions or limitations of coverage. Please consult your

53 insurance agent to determine which Florida state-mandated
54 benefits are excluded under this ...(name of health
55 insurance product)....
56
57 (5) The foreign insurer establishes a grievance procedure
58 for residents of this state who purchase individual health
59 insurance offered for sale under this section.
60 Section 2. This act shall take effect July 1, 2016.

HB 1327

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1327 Sinkhole Insurance
SPONSOR(S): Ingoglia
TIED BILLS: **IDEN./SIM. BILLS:** SB 1274

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Lloyd	Luczynski
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

A sinkhole is defined in law as a landform created by subsidence of soil, sediment, or rock as underlying strata are dissolved by groundwater. Catastrophic ground cover collapse is also defined in the law and is more severe than sinkhole loss. Florida law requires property insurers to cover only catastrophic ground cover collapse, rather than all sinkhole loss, in the base property insurance policy. But, insurers must also offer policyholders sinkhole loss coverage, for an appropriate additional premium.

Currently to recover under a sinkhole insurance policy a homeowner must have experienced sinkhole loss. Sinkhole loss means structural damage to the covered building, including the foundation, caused by sinkhole activity. Contents coverage and additional living expenses apply only if there is structural damage to the covered building caused by sinkhole activity.

In 2011, the Legislature reviewed the sinkhole law and enacted comprehensive reforms addressing all areas of the law, including defining structural damage. The reforms were in response to the increasing number and cost of sinkhole claims. The goal of the reforms was to keep sinkhole loss insurance available to homeowners while providing more certainty in sinkhole claims for homeowners and insurers in terms of coverage, costs, repairs, and exposure.

The bill creates a new type of sinkhole coverage. Among its key features, the bill:

- Permits an authorized insurer to issue an insurance policy providing personal lines residential coverage for the peril of sinkholes on any structure or the contents of personal property.
- Does not apply to commercial lines residential, commercial lines nonresidential coverage, or excess coverage for the peril of sinkholes.
- Covers only losses from the perils of sinkholes as the term "sinkhole" is currently defined in law.
- Requires that any loss under personal property or contents coverage that is repaired or replaced be adjusted only on the basis of replacement costs up to the policy limits. (Prohibits adjustment based on actual cash value).
- Provides that any limitations on sinkhole coverage or policy limits, including, but not limited to, deductibles, must be prominently noted on the policy declarations page or face page.
- Establishes new surplus requirements for new and current insurers of this new coverage.
- Until October 1, 2019, these sinkhole insurers will not be subject to file and use rate review by the Office of Insurance Regulation.
- Requires the Florida Commission on Hurricane Loss Projection Methodology (Commission) to review sinkhole loss models and develop standards by July 1, 2018.

The bill has a definite but currently indeterminate fiscal impact on the Commission and on the private sector. The bill has no effect on local government.

The bill is effective date upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

A sinkhole is defined in Florida law as a landform created by subsidence of soil, sediment, or rock as underlying strata are dissolved by groundwater.[1] Sinkholes occur in certain parts of Florida due to the unique geological structure of the land. Sinkholes are geographic features formed by movement of rock or sediment into voids created by the dissolution of water-soluble rock. This type of subsidence formation may be aggravated and accelerated by urbanization and suburbanization, by water usage and changes in weather patterns.

Since 1981, insurers offering property coverage in Florida have been required by law to provide coverage for property damage from sinkholes.[2] In 2007, Florida law was amended to require insurers in Florida to cover only catastrophic ground cover collapse, rather than all sinkhole loss, in the base property insurance policy.[3] Catastrophic ground cover collapse is more severe than sinkhole loss. Catastrophic ground cover collapse means geological activity that result in all the following:

1. The abrupt collapse of the ground cover;
2. A depression in the ground cover clearly visible to the naked eye;
3. Structural damage to the covered building, including the foundation; and
4. The insured structure being condemned and ordered to be vacated by the governmental agency authorized by law to issue such an order for that structure.[4]

Insurers must also offer policyholders, for an appropriate additional premium, sinkhole loss coverage covering any structure, including personal property contents.[5] Such coverage is subject to the insurer's approved underwriting and insurability guidelines. At a minimum, sinkhole loss coverage includes repairing the covered building, repairing the foundation, and stabilizing the underlying land. All property insurers can restrict catastrophic ground cover collapse and sinkhole loss coverage to the property's principal building. However, by law, Citizens Property Insurance Corporation (Citizens)[6] sinkhole loss coverage does not cover sinkhole losses to appurtenant structures, driveways, sidewalks, decks, or patios. Furthermore, insurers can require an inspection of the property before providing sinkhole loss coverage.

For sinkhole loss coverage in residential property insurance, current law allows insurers to include a deductible that applies only to sinkhole loss in the following amounts: 1 percent, 2 percent, 5 percent, or 10 percent of policy dwelling limits. The insurer has the option to choose which sinkhole loss deductible is offered to policyholders and currently, most insurers, including Citizens, offer policyholders only a 10 percent sinkhole loss deductible.

Substantial changes to Florida's sinkhole law occurred in 2005, 2006, and 2011.[7] In 2011, the Legislature reviewed the sinkhole law and enacted comprehensive reforms addressing all areas of the law. Data collected by the Office of Insurance Regulation (OIR) in 2010, before the reforms were

[1] s. 627.706(2)(b), F.S.
[2] Ch. 1981-280, Laws of Fla.
[3] s. 30, Ch. 2007-1, Laws of Fla.
[4] s. 627.706(2)(a), F.S.
[5] s. 627.706, F.S.
[6] Citizens Property Insurance Corporation is a state-created, not-for-profit, tax-exempt governmental entity whose public purpose is to provide property insurance coverage to those unable to find affordable coverage in the voluntary admitted market. It is not a private insurance company.
[7] Chs. 2005-111, 2006-12, and 2011-39, Laws of Fla.

enacted, showed a significant increase in the number and cost of sinkhole claims from 2006 to 2010.[8] These increases impacted the financial stability of property insurers in Florida, including Citizens, and were used by insurers to justify property insurance rate increases.

The sinkhole reforms enacted in 2011 were in response to the increasing number and cost of sinkhole claims. The goal of the reforms was to keep sinkhole loss insurance available to homeowners while providing more certainty in sinkhole claims for homeowners and insurers in terms of coverage, costs, repairs, and exposure.

The first complete year the reforms were in effect was 2012.[9] No data has been collected on an industry-wide basis on the number of claims, claim severity, or claim costs since the reforms were enacted, so their impact on sinkhole claims and costs on an industry-wide basis is unknown. However, Citizens performed a sinkhole study in 2012 to compute the impact of the 2011 reforms on their policies.[10] This study looked at actual sinkhole claim files from Citizens and readjusted the losses and expenses associated with the claims as if the 2011 reforms had been in effect. The actuarial analysis which accompanied the study projected the 2011 reforms would reduce Citizens' expected incurred sinkhole losses for 2013 by almost 55 percent. In Citizens' rate filing for 2014,[11] their actuary projected Citizens' sinkhole losses would decrease by over 52 percent relative to what they would have been without the 2011 reforms. The actuary further noted, however, that even with the projected reduction in sinkhole losses, Citizens still has a significant rate deficiency in the sinkhole area. In fact, in 2012, Citizens earned almost $57 million in sinkhole premium but paid almost $227 million in sinkhole losses and expenses.

According to data from Citizens,[12] in 2013, new sinkhole claim volume was down 61 percent from 2012. Also, Citizens had 54 percent fewer pending sinkhole claims in 2013 than 2012. Paid indemnity, outstanding indemnity reserves, and loss adjustment expenses paid to date for sinkhole claims filed against Citizens have also decreased in 2013 when compared to 2012. This declining trend continued into 2014 and 2015 and, according to Citizens, is attributable largely to the major sinkhole claims reform enacted in 2011.[13]

Sinkhole Insurance

Current law regarding sinkhole insurance includes the following requirements:

- Every property insurer must provide coverage for catastrophic ground cover collapse.
- Each property insurer must offer coverage for sinkhole loss, for an appropriate additional premium, on any structure including the contents of personal property.
- A policy for residential property insurance may include a deductible amount applicable to sinkhole losses equal to 1 percent, 2 percent, 5 percent, or 10 percent of the policy dwelling limits, with appropriate premium discounts offered with each deductible amount.

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[8] *Report on Review of the 2010 Sinkhole Data Call by the Office of Insurance Regulation*, Nov. 8, 2010, http://www.floir.com/siteDocuments/Sinkholes/2010_Sinkhole_Data_Call_Report.pdf (last visited Jan. 29, 2016).
[9] The reforms were effective on May 17, 2011 when the bill (CS/CS/CS/SB 408) was signed by the Governor.
[10] *Citizens Property Insurance Corporation Senate Bill 408 Sinkhole Analysis*, prepared by Insurance Services Office, dated Jul. 19, 2012, and presented at Citizens' Board of Governors Meeting on Jul. 27, 2012, https://www.citizensfla.com/about/mDetails_boardmtgs.cfm?show=PDF&link=/bnc_meet/docs/419/07AH_Citizens_SB408__Sinkhole__Analysis.pdf&event=419&when=Past (last visited Jan. 29, 2016).
[11] Information on Citizens' 2014 rate filing is available at https://www.citizensfla.com/about/mediaresources.cfm (last visited Jan. 29, 2016).
[12] Data is as of the end of September 2013 and is available in meeting materials from the Citizens' Claims Committee meeting on Nov. 14, 2013, available at https://www.citizensfla.com/about/mDetails_boardmtgs.cfm?event=531&when=Past (last visited Jan. 29, 2016).
[13] *Citizens Property Insurance Corporation Actuarial & Underwriting Committee Recommended Rate Filing Executive Summary*, Jun. 23, 2015 at https://www.citizensfla.com/about/mDetails_boardmtgs.cfm?show=PDF&link=/bnc_meet/docs/604/02_2016_Annual_Recommended_Rate_Filing_Exec_Summary.pdf&event=604&when=Past (last visited Jan. 29, 2016).

There are four terms in statute[14] that, when read together, describe what is currently meant by sinkhole insurance. These terms are:

1. "Sinkhole" means a landform created by subsidence of soil, sediment, or rock as underlying strata are dissolved by groundwater. A sinkhole forms by collapse into subterranean voids created by dissolution of limestone or dolostone or by subsidence as these strata are dissolved.

2. "Sinkhole activity" means settlement or systematic weakening of the earth supporting the covered building only if the settlement or systematic weakening results from contemporaneous movement or raveling of soils, sediments, or rock materials into subterranean voids created by the effect of water on a limestone or similar rock formation.

3. "Sinkhole loss" means structural damage to the covered building, including the foundation, caused by sinkhole activity. Contents coverage and additional living expenses apply only if there is structural damage to the covered building caused by sinkhole activity.

4. "Structural damage" means a covered building, regardless of the date of its construction, has experienced the following:

   (a) Interior floor displacement or deflection in excess of acceptable variances as defined in ACI 117-90[15] or the Florida Building Code, which results in settlement-related damage to the interior such that the interior building structure or members become unfit for service or represents a safety hazard as defined within the Florida Building Code;
   (b) Foundation displacement or deflection in excess of acceptable variances as defined in ACI 318-95 or the Florida Building Code, which results in settlement-related damage to the primary structural members or primary structural systems that prevents those members or systems from supporting the loads and forces they were designed to support to the extent that stresses in those primary structural members or primary structural systems exceeds one and one-third the nominal strength allowed under the Florida Building Code for new buildings of similar structure, purpose, or location;
   (c) Damage that results in listing, leaning, or buckling of the exterior load-bearing walls or other vertical primary structural members to such an extent that a plumb line passing through the center of gravity does not fall inside the middle one-third of the base as defined within the Florida Building Code;
   (d) Damage that results in the building, or any portion of the building containing primary structural members or primary structural systems, being significantly likely to imminently collapse because of the movement or instability of the ground within the influence zone of the supporting ground within the sheer plane necessary for the purpose of supporting such building as defined within the Florida Building Code; or
   (e) Damage occurring on or after October 15, 2005, that qualifies as "substantial structural damage" as defined in the Florida Building Code.

Under current law, sinkhole insurance means coverage for sinkhole loss which includes structural damage caused by sinkhole activity. The definition of sinkhole does not include either term. To file a sinkhole claim and recover payment, there must be structural damage to the covered building, including the foundation, caused by sinkhole activity. If a homeowner only has a "sinkhole" as that term is currently defined, the policyholder will not be covered (unless the sinkhole falls within the definition of catastrophic ground cover collapse).

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[14] s. 627.706(2) (h)(i)(j) and (k), F.S.
[15] The American Concrete Institute develops and distributes consensus based standards for concrete design, construction and materials. More information and copies of their standards documents are available at https://www.concrete.org/aboutaci.aspx (last visited Jan. 29, 2016).

Effect of the Bill

The bill creates a new type of sinkhole coverage. Among its key features regarding coverage, the bill:

- Permits an authorized insurer to issue an insurance policy providing personal lines residential coverage for the peril of sinkholes on any structure or the contents of personal property.
- Does not apply to commercial lines residential or commercial lines nonresidential coverage for the peril of sinkholes; it also does not apply to coverage for the peril of sinkholes that is excess coverage over any other insurance covering the peril of sinkholes.
- Covers only losses from the perils of sinkholes as the term "sinkhole" is currently defined in law.
- Requires coverage for additional living expenses.
- Requires that any loss under personal property or contents coverage that is repaired or replaced be adjusted only on the basis of replacement costs up to the policy limits. (Prohibits adjustment based on actual cash value).
- Provides that any limitations on sinkhole coverage or policy limits, including, but not limited to, deductibles, must be prominently noted on the policy declarations page or face page.

The most significant change is the new type of insurance coverage being created. Whereas now sinkhole insurance covers sinkhole loss, which requires there to have been sinkhole activity that caused structural damage to the covered building, including the foundation, the bill allows a new type of insurance policy to be offered that mandates that the coverage be for "sinkholes" which does not include structural damage or sinkhole activity. This will result in a broader definition of coverage, surpassing that which was in place prior to the 2011 reforms.

Surplus Requirements

New Insurers

To transact insurance in Florida, insurers must apply for a certificate of authority and meet certain surplus requirements. For a new domestic insurer that transacts residential property insurance and is:

- Not a wholly owned subsidiary of an insurer domiciled in any other state, the surplus requirement is at least $15 million.
- A wholly owned subsidiary of an insurer domiciled in any other state, the requirement is at least $50 million.

Effect of the Bill

For a new domestic insurer that *only* transacts sinkhole insurance for personal lines residential property pursuant to s. 627.7151, F.S., (new section created in the bill) the bill lowers the surplus requirement. For those entities, the insurer must possess a surplus of at least $2.5 million.

Existing Insurers

Under current law, the surplus requirements for existing insurers are different than the requirements for new insurers. For property and casualty insurers, the requirement is $4 million, except for property and casualty insurers authorized to underwrite any line of residential property insurance. For residential property insurers not holding a certificate of authority before July 1, 2011, the requirement is $15 million. For residential property insurers holding a certificate of authority before July 1, 2011, and until June 30, 2016, $5 million; on or after July 1, 2016, and until June 30, 2021, $10 million; on or after July 1, 2021, $15 million.

Effect of the Bill

The bill also lowers the surplus requirement for existing insurers. For an existing domestic insurer that *only* transacts sinkhole insurance for personal lines residential property pursuant to s. 627.7151, F.S., the surplus requirement is $1.5 million.

Sinkhole Insurance Rates

Rates for property, casualty, and surety insurance cannot be excessive, inadequate, or unfairly discriminatory.[16] When an insurer submits a rate to the OIR for a full rate review, the OIR uses statutory factors and rate standards found in s. 627.062(2), F.S., to determine if a rate is excessive, inadequate, or unfairly discriminatory. If a sinkhole insurer opts to file its sinkhole insurance rates with the OIR for approval before using the rates, the rates cannot be excessive, inadequate, or unfairly discriminatory. To make this determination, the OIR will use the same statutory factors and rate standards that it uses for rates for property, casualty, and surety insurance.

Effect of the Bill

The bill allows insurers providing personal lines residential coverage for sinkholes to develop rates for the coverage two ways:

- Use the rate after filing with and approval by the OIR.
- Use the rate without filing with or approval by the OIR.

Insurers can only use the second way to develop sinkhole insurance rates until October 1, 2019. After this date, all insurers must use the first option which requires a full rate review and approval by the OIR before a sinkhole insurance rate can be used.

The bill allows insurers to use a rate for sinkhole coverage without filing it or obtaining approval of it from the OIR; however, a rate set this way still cannot be excessive, inadequate, or unfairly discriminatory, the same rate requirement for rates filed with and approved by the OIR. The insurer writing the sinkhole insurance is responsible for ensuring the rate charged meets this requirement. The bill allows the OIR to examine an insurer's documentation supporting a rate to verify the rate meets the requirement with the insurer paying for the examination. During an examination, the OIR uses the rate factors and standards in current law that apply to property, casualty and surety insurance rates filed with the OIR to determine whether the sinkhole insurance rate charged is excessive, inadequate, or unfairly discriminatory. Additionally, the insurer must notify the OIR within 30 days of a rate change for sinkhole insurance that was originally set by this method. Setting sinkhole rates using this method is similar to what is allowed in current law for rates for flood insurance and certain types of commercial lines risks under s. 627.062(3)(d), F.S.

Use of Sinkhole Loss Models to Set Sinkhole Rates

In 1995 the Legislature established the Florida Commission on Hurricane Loss Projection Methodology (Commission) to serve as an independent body within the State Board of Administration.[17] The Commission is comprised of 12 members. Members include experts in insurance finance, statistics, computer system design, structural engineering, and meteorology who are full-time faculty members in the State University System, three actuaries, the Executive Director of Citizens, the senior employee responsible for Florida Hurricane Catastrophe Fund operations, the Insurance Consumer Advocate, and the Director of Emergency Management. The Commission sets standards for hurricane loss projection methodology and examines the methods employed in proprietary hurricane loss models

[16] s. 627.062(1), F.S.
[17] The Commission is created in s. 627.0628, F.S. This statute also provides the composition and duties of the Commission.

used by private insurers in setting property insurance rates to determine whether they meet the Commission's standards.

The Commission adopts findings on the accuracy or reliability of the methods, standards, principles, models and other means used to project hurricane losses. Only hurricane loss models or methods the Commission deems accurate or reliable can be used by insurers in rate filings to estimate hurricane losses used to set property insurance rates.

Effect of the Bill

The duties of the Commission are expanded by the bill to require the Commission to adopt, by July 1, 2018, actuarial methods, principles, standards, models, or output ranges for sinkhole loss to be used in setting rates for personal lines residential sinkhole coverage.

The bill also requires the OIR to consider projected sinkhole losses from models or methods found to be acceptable or reliable by the Commission or a straight average of the model results for a rate filing that includes sinkhole coverage. To support a sinkhole insurance rate, for those filed with and approved by the OIR before use, the bill allows sinkhole losses to be projected by a sinkhole loss model found acceptable or reliable by the Commission. For sinkhole rates not filed with or approved by the OIR, if the OIR examines the rate after use, it will consider whether the insurer's sinkhole rates were set based on sinkhole losses projected by a Commission approved model.

Sinkhole Insurance in the Surplus Lines Market

Currently, no insurance coverage is eligible for export to a surplus lines insurer unless it meets certain conditions. One condition is that an agent has sought coverage from and received three documented rejections from authorized insurers currently writing the same type of coverage.

Effect of the Bill

Until July 1, 2020, the bill allows this new sinkhole coverage for personal lines residential property to be written by a surplus lines insurer without the agent obtaining three declinations for insurance from Florida licensed sinkhole insurers. This provision tracks the same language in place for flood insurance regarding surplus lines insurers. However, the other requirements governing the exporting of coverage to the surplus lines continue to apply.

Catastrophic Ground Cover Collapse

Citizens, just like all other property insurers, already must include catastrophic ground cover collapse coverage in all its policies.

Effect of the Bill

The bill requires Citizens to provide coverage for catastrophic ground cover collapse. The effect of this provision is unclear. Absent clarification, the effect may be to require Citizens to write such coverage as a stand-alone policy, regardless of underwriting risk. This interpretation would have significant impact on Citizens.

Superseding of Other Law

The Florida Insurance Code covers a comprehensive array of property insurance measures related to forms, contracts, trade practice, market conduct, rates, consumer protections, solvency and other regulatory matters.

Effect of the Bill

The bill provides that with respect to the regulation of sinkhole coverage written in this state by authorized insurers, the provisions in the bill supersedes any other provision of the Florida Insurance Code in the event of a conflict. Because this broadly supersedes the entire Insurance Code, the effect of the bill on insurance regulation is unknown.

Other Regulatory Requirements

In addition to other requirements in the bill, insurers providing sinkhole coverage are to notify the OIR at least 30 days before writing sinkhole insurance in this state. They also must file a plan of operation and financial projections or revisions to such plan, as applicable, with the OIR.

B. SECTION DIRECTORY:

Section 1. Amends s. 624.407, F.S., relating to surplus required; new insurers.

Section 2. Amends s. 624.408, F.S., relating to surplus; current insurers.

Section 3. Amends s. 627.062, F.S., relating to rate standards.

Section 4. Amends s. 627.0628, F.S., relating to Florida Commission on Hurricane Loss Projection Methodology.

Section 5. Creates s. 627.7151, F.S., relating to sinkhole insurance.

Section 6. Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill requires the Florida Commission on Hurricane Loss Methodology (Commission) to develop standards for review of sinkhole loss models. This entails additional Commission meetings, research, workshops, consultants, and possible meetings at each sinkhole modeler's location. The cost for these new tasks is unknown.[18]

   The Commission is funded by the Florida Hurricane Catastrophe Fund (Fund) so the additional costs will be paid from the Fund. The Fund is a tax-exempt trust fund created in 1993 as a form of reinsurance for residential property insurers. Each insurance company writing insurance policies covering residential property or any policy covering a residential structure or its contents must buy specified reinsurance coverage from the Fund and pays a premium to the fund for the reinsurance purchased. The Fund does not receive any state funding (from the General Revenue Fund or other state trust funds) and receives its funding from the reinsurance premium it charges insurers and investment income from investing the reinsurance premium received.

[18] The estimated cost for the first year of implementing the new responsibilities for the Commission regarding flood modeling was $350,000. *House of Representatives Final Bill Analysis for CS/CS/ 879*, Jun. 16, 2014, http://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=h0879z1.IBS.DOCX&DocumentType=Analysis&BillNumber=0879&Session=2014 (last visited Jan. 29, 2016).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The economic impact on the private sector is unknown. Broadening the coverage to insure all sinkholes regardless of whether there is sinkhole activity and structural damage may drive up the cost of coverage for homeowners. If insurers offering this new sinkhole insurance raise deductibles and initiate limits on coverage (sub-limits), policyholders may have lower premiums. However, if a policy holder experienced a sinkhole, the costs to the policyholder would be higher.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Regarding modeling and the involvement of the Commission, the bill delineates procedures for sinkhole loss. The inclusion of the term "sinkhole loss" in these sections raises a drafting/intent issue. The term "sinkhole loss" is narrower than the new policy type created by the bill for "the peril of sinkholes." Sinkhole loss narrows the focus of the Commission and does not match up with the new, broader coverage of "the peril of sinkholes" provided by the bill. Therefore, the usefulness of the data and its application may be limited.

Section 6 of the bill provides for an effective date of becoming a law. Due to the complexity of insurance products, most insurance bills of this magnitude allow more time to prepare for implementation.

The bill requires limitations on policy limits, including deductibles, to be prominently noted on the policy declarations page or face page, however the bill does not expressly authorize limitations on policy limits.

In its bill analysis[19], OIR identified several issues of concern. There comments are as follows:

[19] Florida Office of Insurance Regulation, Agency Analysis of 2016 HB 1327, (Jan. 28, 2016).

The proposed reduced surplus requirements for new or existing domestic sinkhole-only insurers may be too low. Sinkhole is a high-severity coverage which can cause significant losses, so the proposed surplus requirements may be insufficient. A single sinkhole loss could include major structural damage to the building, including the foundation. This loss could be significant and considering the risks that sinkholes present in Florida, reducing surplus requirements for this peril raises solvency concerns. Other insurers may object to being assessed by the Florida Insurance Guaranty Association for unpaid claims of a sinkhole-only insurer that is funded with less capital.

The bill has specific provisions for a domestic residential insurer that solely writes sinkhole coverage but it does not specifically mention a non-domestic insurer. The bill should provide clarity with regard to a non-domestic insurer.

This bill proposes the essential deregulation of personal lines sinkhole-only rates until October 1, 2019, which is similar to current statutory language for private flood rates. Applying this provision to new sinkhole-only rates seems to create an inconsistency with companies which already have sinkhole rates on file that have been approved. The result would seem to be that rates for sinkhole-only insurers would be deregulated while the rates for multi-peril personal residential property insurers that include coverage for sinkhole would not. Since insurers already have rates approved for sinkhole coverage, unlike the situation for private flood coverage, it is not clear why suspension of the application of rating statutes for sinkhole–only coverage is necessary or advisable.

The Florida Hurricane Loss Projection Methodology Commission was created to develop loss models for hurricanes. It is not clear whether or not the Commission has the necessary knowledge and expertise in geology and engineering science to evaluate sinkhole loss projections. Since sinkhole rate filings are currently based on historical losses and not sinkhole loss models, it is unknown if the use of new models will have an impact on the rates that an insurer would charge, whether as a sinkhole-only insurer or as a residential property insurer.

It is not clear if the provisions of Section 5 apply just to sinkhole-only insurers, or if they apply to any authorized insurer issuing a personal lines residential property policy which covers the peril of sinkhole. Since there are already provisions of law that apply to authorized insurers issuing policies which cover the peril of sinkhole, clarification of the application of Section 5 is important, particularly since the provisions of that section supersede any other provisions of the Florida Insurance Code. It is unclear which statutes are superseded and this lack of clarity could present significant issues.

Assuming that Section 5 applies just to sinkhole-only insurers, that provision would require such insurance to cover only what is now defined as "sinkhole loss" in Section 627.706(2), Florida Statutes, but would require replacement cost coverage for personal property or contents coverage, which is normally initially offered on an actual cash value. This would mean that sinkhole coverage for policyholders would differ depending on whether the coverage was purchased from a sinkhole-only insurer or a personal lines residential property insurer. Presumably no other consumer protection policy provisions could be required of sinkhole-only insurers because of the supersedence provision.

Section 5 also requires "Any limitations on sinkhole coverage or policy limits...." to be prominently noted on the declarations page. To require sinkhole-only insurers to include "any" limitations (which would include all exclusions) in the manner proposed

could prove challenging, and may actually result in diluting the impact of the limitations. It may be appropriate to consider amending this language, similar to that found in Section 627.715(2), Florida Statutes, to provide "Sinkhole-only insurance coverage deductibles and policy limits pursuant to this section must be prominently noted on the policy declarations page or face page."

It appears the bill is trying to set up a separate market for the sinkhole coverage at rates that are not subject to OIR approval until October 1, 2019. While it is possible now for insurers to write solely sinkhole insurance, none are doing so. It is unclear whether insurers would be willing to write this high severity coverage on a standalone basis, and whether that financial business model could be successful.

The bill states that its provisions supersede any other provision in the Florida Insurance Code, in the event of a conflict. This broad provision could lead to some confusion as to what requirements apply to "the regulation of sinkhole coverage written in this state by authorized insurers."

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to sinkhole insurance; amending s.
3 624.407, F.S.; specifying the amount of surplus funds
4 required for domestic insurers applying for a
5 certificate of authority to provide sinkhole
6 insurance; amending s. 624.408, F.S.; specifying the
7 minimum surplus that must be maintained by insurers
8 that provide sinkhole insurance; amending s. 627.062,
9 F.S.; adding projected sinkhole losses to the factors
10 that must be considered by the Office of Insurance
11 Regulation in reviewing certain rate filings; amending
12 s. 627.0628, F.S.; requiring the Florida Commission on
13 Hurricane Loss Projection Methodology to adopt
14 standards and guidelines relating to personal lines
15 residential sinkhole loss by a specified date;
16 creating s. 627.7151, F.S.; authorizing certain
17 insurers to offer sinkhole insurance in this state;
18 requiring that certain limitations be noted on the
19 policy declarations or face page; providing an insurer
20 with rate options; authorizing a surplus lines agent
21 to export a contract or endorsement for sinkhole
22 coverage to a surplus lines insurer without meeting
23 certain requirements; requiring the insurer to notify
24 the office before writing sinkhole insurance and to
25 file a plan of operation with the office; requiring
26 Citizens Property Insurance Corporation to provide

27 coverage for catastrophic ground cover collapse;
28 providing construction; providing an effective date.
29
30 Be It Enacted by the Legislature of the State of Florida:
31
32 Section 1. Subsection (1) of section 624.407, Florida
33 Statutes, is amended to read:
34 624.407 Surplus required; new insurers.—
35 (1) To receive authority to transact any one kind or
36 combinations of kinds of insurance, as defined in part V of this
37 chapter, an insurer applying for its original certificate of
38 authority in this state shall possess surplus as to
39 policyholders at least the greater of:
40 (a) For a property and casualty insurer, $5 million, or
41 $2.5 million for any other insurer;
42 (b) For life insurers, 4 percent of the insurer's total
43 liabilities;
44 (c) For life and health insurers, 4 percent of the
45 insurer's total liabilities, plus 6 percent of the insurer's
46 liabilities relative to health insurance;
47 (d) For all insurers other than life insurers and life and
48 health insurers, 10 percent of the insurer's total liabilities;
49 ~~or~~
50 (e) Notwithstanding paragraph (a) or paragraph (d), for a
51 domestic insurer that transacts residential property insurance
52 and is:

53 1. Not a wholly owned subsidiary of an insurer domiciled
54 in any other state, $15 million.
55 2. A wholly owned subsidiary of an insurer domiciled in
56 any other state, $50 million; or
57 (f) Notwithstanding paragraphs (a), (d), and (e), for a
58 domestic insurer that only transacts sinkhole insurance for
59 personal lines residential property pursuant to s. 627.7151,
60 $2.5 million.
61 Section 2. Paragraph (h) is added to subsection (1) of
62 section 624.408, Florida Statutes, to read:
63 624.408 Surplus required; current insurers.—
64 (1) To maintain a certificate of authority to transact any
65 one kind or combinations of kinds of insurance, as defined in
66 part V of this chapter, an insurer in this state must at all
67 times maintain surplus as to policyholders at least the greater
68 of:
69 (h) Notwithstanding paragraphs (e), (f), and (g), for a
70 domestic insurer that only transacts sinkhole insurance for
71 personal lines residential property pursuant to s. 627.7151,
72 $1.5 million.
73
74 The office may reduce the surplus requirement in paragraphs (f)
75 and (g) if the insurer is not writing new business, has premiums
76 in force of less than $1 million per year in residential
77 property insurance, or is a mutual insurance company.
78 Section 3. Paragraph (b) of subsection (2) of section

79 627.062, Florida Statutes, is amended to read:
80 627.062 Rate standards.—
81 (2) As to all such classes of insurance:
82 (b) Upon receiving a rate filing, the office shall review
83 the filing to determine whether ~~if~~ a rate is excessive,
84 inadequate, or unfairly discriminatory. In making that
85 determination, the office shall, in accordance with generally
86 accepted and reasonable actuarial techniques, consider the
87 following factors:
88 1. Past and prospective loss experience within and without
89 this state.
90 2. Past and prospective expenses.
91 3. The degree of competition among insurers for the risk
92 insured.
93 4. Investment income reasonably expected by the insurer,
94 consistent with the insurer's investment practices, from
95 investable premiums anticipated in the filing, plus any other
96 expected income from currently invested assets representing the
97 amount expected on unearned premium reserves and loss reserves.
98 The commission may adopt rules using reasonable techniques of
99 actuarial science and economics to specify the manner in which
100 insurers calculate investment income attributable to classes of
101 insurance written in this state and the manner in which
102 investment income is used to calculate insurance rates. Such
103 manner must contemplate allowances for an underwriting profit
104 factor and full consideration of investment income that produces

105 a reasonable rate of return; however, investment income from
106 invested surplus may not be considered.
107 5. The reasonableness of the judgment reflected in the
108 filing.
109 6. Dividends, savings, or unabsorbed premium deposits
110 allowed or returned to policyholders, members, or subscribers in
111 this state.
112 7. The adequacy of loss reserves.
113 8. The cost of reinsurance. The office may not disapprove
114 a rate as excessive solely due to the insurer having obtained
115 catastrophic reinsurance to cover the insurer's estimated 250-
116 year probable maximum loss or any lower level of loss.
117 9. Trend factors, including trends in actual losses per
118 insured unit for the insurer making the filing.
119 10. Conflagration and catastrophe hazards, if applicable.
120 11. Projected hurricane losses, if applicable, which must
121 be estimated using a model or method found to be acceptable or
122 reliable by the Florida Commission on Hurricane Loss Projection
123 Methodology, and as further provided in s. 627.0628.
124 12. Projected flood <u>and sinkhole</u> losses for personal
125 residential property insurance, if applicable, which may be
126 estimated using a model or method, or a straight average of
127 model results or output ranges, independently found to be
128 acceptable or reliable by the Florida Commission on Hurricane
129 Loss Projection Methodology and as further provided in s.
130 627.0628.

131 13. A reasonable margin for underwriting profit and
132 contingencies.
133 14. The cost of medical services, if applicable.
134 15. Other relevant factors that affect the frequency or
135 severity of claims or expenses.
136
137 The provisions of this subsection do not apply to workers'
138 compensation, employer's liability insurance, and motor vehicle
139 insurance.
140 Section 4. Paragraphs (a), (d), and (e) of subsection (3)
141 of section 627.0628, Florida Statutes, are amended to read:
142 627.0628 Florida Commission on Hurricane Loss Projection
143 Methodology; public records exemption; public meetings
144 exemption.—
145 (3) ADOPTION AND EFFECT OF STANDARDS AND GUIDELINES.—
146 (a) The commission shall consider any actuarial methods,
147 principles, standards, models, or output ranges that have the
148 potential for improving the accuracy of or reliability of the
149 hurricane loss projections used in residential property
150 insurance rate filings, ~~and~~ flood loss projections used in rate
151 filings for personal lines residential flood insurance coverage,
152 and sinkhole loss projections used in rate filings for personal
153 lines residential sinkhole insurance coverage. The commission
154 shall, from time to time, adopt findings as to the accuracy or
155 reliability of particular methods, principles, standards,
156 models, or output ranges.

157 (d) With respect to a rate filing under s. 627.062, an
158 insurer shall employ and may not modify or adjust actuarial
159 methods, principles, standards, models, or output ranges found
160 by the commission to be accurate or reliable in determining
161 hurricane loss factors and probable maximum loss levels for use
162 in a rate filing under s. 627.062. An insurer may employ a model
163 in a rate filing until 120 days after the expiration of the
164 commission's acceptance of that model and may not modify or
165 adjust models found by the commission to be accurate or reliable
166 in determining probable maximum loss levels. This paragraph does
167 not prohibit an insurer from using a straight average of model
168 results or output ranges for the purposes of a rate filing for
169 personal lines residential flood insurance coverage or personal
170 lines residential sinkhole insurance coverage under s. 627.062.
171 (e)1. The commission shall adopt actuarial methods,
172 principles, standards, models, or output ranges for personal
173 lines residential flood loss no later than July 1, 2017.
174 2. The commission shall adopt actuarial methods,
175 principles, standards, models, or output ranges for personal
176 lines residential sinkhole loss no later than July 1, 2018.
177 Section 5. Section 627.7151, Florida Statutes, is created
178 to read:
179 627.7151 Sinkhole insurance.—
180 (1) An authorized insurer may issue an insurance policy
181 providing personal lines residential coverage for the peril of
182 sinkholes on any structure or the contents of personal property

183 contained therein, subject to this section and s. 627.706. This
184 section does not apply to commercial lines residential or
185 commercial lines nonresidential coverage for the peril of
186 sinkholes. This section also does not apply to coverage for the
187 peril of sinkholes that is excess coverage over any other
188 insurance covering the peril of sinkholes.
189 (2) Sinkhole insurance must:
190 (a) Cover only losses from the peril of sinkholes, as
191 defined in s. 627.706(2)(h).
192 (b) Include coverage for additional living expenses.
193 (c) Require that any loss under personal property or
194 contents coverage that is repaired or replaced be adjusted only
195 on the basis of replacement costs up to the policy limits.
196 (3) Any limitations on sinkhole coverage or policy limits,
197 including, but not limited to, deductibles, must be prominently
198 noted on the policy declarations page or face page.
199 (4)(a) An insurer may establish and use sinkhole coverage
200 rates in accordance with the rate standards provided in s.
201 627.062.
202 (b) For sinkhole coverage rates filed with the office
203 before October 1, 2019, the insurer may also establish and use
204 such rates in accordance with the rates, rating schedules, or
205 rating manuals filed by the insurer with the office which allow
206 the insurer a reasonable rate of return on sinkhole coverage
207 written in this state. Sinkhole coverage rates established
208 pursuant to this paragraph are not subject to s. 627.062(2)(a)

209 or (f). An insurer shall notify the office of any change to such
210 rates within 30 days after the effective date of the change. The
211 notice must include the name of the insurer and the average
212 statewide percentage change in rates. Actuarial data with regard
213 to such rates for sinkhole coverage must be maintained by the
214 insurer for 2 years after the effective date of such rate change
215 and is subject to examination by the office. The office may
216 require the insurer to incur the costs associated with an
217 examination. Upon examination, the office, in accordance with
218 generally accepted and reasonable actuarial techniques, shall
219 consider the rate factors in s. 627.062(2)(b) and (d), and the
220 standards in s. 627.062(2)(e), to determine whether the rate is
221 excessive, inadequate, or unfairly discriminatory.
222 (5) A surplus lines agent may export sinkhole insurance to
223 an eligible surplus lines insurer without making a diligent
224 effort to seek such coverage from three or more authorized
225 insurers under s. 626.916(1)(a). This subsection expires July 1,
226 2020.
227 (6) In addition to any other applicable requirements, an
228 insurer providing sinkhole coverage in this state must:
229 (a) Notify the office at least 30 days before writing
230 sinkhole insurance in this state.
231 (b) File a plan of operation and financial projections or
232 revisions to such plan, as applicable, with the office.
233 (7) Citizens Property Insurance Corporation shall provide
234 coverage for catastrophic ground cover collapse as defined in s.

235 627.706(2)(a).
236 (8) With respect to the regulation of sinkhole coverage
237 written in this state by authorized insurers, this section
238 supersedes any other provision of the Florida Insurance Code in
239 the event of a conflict.
240 Section 6. This act shall take effect upon becoming a law.

HB 1425

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1425 Consumer Finance
SPONSOR(S): Fant
TIED BILLS: **IDEN./SIM. BILLS:** SB 1696

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Insurance & Banking Subcommittee		Bauer	Luczynski
2) Government Operations Appropriations Subcommittee			
3) Regulatory Affairs Committee			

SUMMARY ANALYSIS

The Florida Office of Financial Regulation (OFR)'s Division of Consumer Finance is responsible for the licensing and regulation of non-depository financial service entities and individuals, and conducts examinations and compliance investigations for licensed entities to determine compliance with Florida law. One of the regulatory programs administered by OFR is the Florida Consumer Finance Act (ch. 516, F.S., "the Act"), which sets forth licensing requirements for consumer finance lenders and the terms and conditions under which a consumer finance loan is permitted in Florida. The Act sets forth maximum interest rates for *consumer finance loans*, which are "loan[s] of money, credit, goods, or a provision of a line of credit, in an amount or to a value of $25,000 or less at an interest rate greater than 18 percent per annum. The allowable interest rates on consumer finance loans are tiered and limited based on the principal amount that falls within each tier of the loan. As the principal amount increases, the allowable interest rate decreases. Pursuant to federal law, the annual percentage rate (APR) for each consumer finance loan must be computed and disclosed to the borrower.

The bill creates a small dollar pilot program in the Act from July 1, 2016 to January 1, 2022, which would permit licensed small lenders to make loans, between $300 and $3,000, at a maximum interest rate of 36 percent per annum. The loans must be unsecured and for a minimum term of 90 days. The bill:

- Requires small loan licensees to be licensed with the OFR in order to impose any charges or fees or use a referral partner;
- Permits origination fees, delinquency charges, bad check (NSF) charges of specified amounts, but prohibits credit insurance and certain waivers of rights;
- Sets forth requirements for credit reporting, underwriting, certain disclosures, receipts, rescission rights, and optional credit counseling;
- Allows small loan licensees to contract with *referral partners*, who provide marketing, servicing, and other ancillary services for the licensees, so long as they do not counsel or advise borrowers or negotiate loan terms;
- Provides that licensees are responsible for violations committed by referral partners;
- Sets forth recordkeeping requirements for licensees, and provides the OFR with examination and enforcement authority;
- Requires licensees to file with OFR by March 15, 2017, and annually thereafter, a report regarding small loans;
- Requires the OFR to publish its program report online by January 1, 2018, and annually thereafter. The report may not identify data by any specific licensee, but must include 20 specified aggregate data points.

The bill has no impact on local governments, an indeterminate impact on state revenues, and a significant negative impact on state expenditures, and an indeterminate impact on the private sector. The number of lenders, referral partners, and borrowers who will participate in the pilot program is unknown.

The bill provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

State Regulation of Consumer Loans

The Florida Office of Financial Regulation (OFR)'s Division of Consumer Finance is responsible for the licensing and regulation of non-depository financial service entities and individuals, and conducts examinations and compliance investigations for licensed entities to determine compliance with Florida law. One of the regulatory programs administered by OFR is the Florida Consumer Finance Act (ch. 516, F.S., "the Act"), which sets forth licensing requirements for consumer finance lenders and the terms and conditions under which a consumer finance loan is permitted in Florida. The Act sets forth maximum interest rates for *consumer finance loans*, which are "loan[s] of money, credit, goods, or a provision of a line of credit, in an amount or to a value of $25,000 or less at an interest rate greater than 18 percent per annum.[1]"

Consumer finance loans may be secured or unsecured. The allowable interest rates on consumer finance loans are tiered and limited based on the principal amount that falls within each tier of the loan. As the principal amount increases, the allowable interest rate decreases. In 2013, the Legislature increased the principal amounts that would be subject to the maximum amount of interest within each tier, so that consumer finance lenders licensed with the OFR may charge a maximum interest rate of:

- 30 percent a year, computed on the first $3,000 of the principal amount,
- 24 percent a year on that part of principal between $3,001 to $4,000, and
- 18 percent per year on that part of principal between $4,001 to $25,000.[2]

These principal amounts are the same as the financed amounts determined by the Federal Truth-in-Lending Act (TILA), and Regulation Z (Reg Z) of the Board of Governors of the Federal Reserve System.[3] The maximum interest rates and finance charges under the Act are computed on a simple-interest basis, and not a compounding or other basis. The APR for all loans under the Act may equal, but cannot exceed, the APR for the loan as required to be computed and disclosed by TILA and Reg Z.[4]

Other than the applicable interest rates described above, the Act allows consumer finance lenders to charge borrowers the following charges and fees[5]:

- Up to $25 for investigating the credit and character of the borrower,
- A $25 annual fee on the anniversary date of each line-of-credit account,
- Brokerage fees for certain loans and appraisals of real property offered as security,
- Intangible personal property tax, if secured by a loan note on real property,
- Documentary excise tax and lawful fees,
- Insurance premiums,
- Actual and reasonable attorney fees and court costs,
- Actual and commercially reasonable expenses for recovering the collateral property,
- Delinquency charges of up to $15 for each payment in default for at least 10 days, if agreed upon in writing before the charge is imposed,
- A bad check charge of up to $20.

Add-on credit insurance products for consumer finance loans must be optional (and not made a condition of the loan), and must comply with the applicable Insurance Code provisions.[6] In particular,

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[1] s. 516.01(2), F.S.
[2] Ch. 2013-124, Laws of Fla. TILA is codified at 15 U.S.C. §1601 et seq.; Reg Z is at 12 C.F.R. pt. 226.
[3] s. 516.031(1), F.S.
[4] s. 516.031(2), F.S.
[5] s 516.031(3), F.S.

credit insurance insures the debtor for loss of life, involuntary unemployment, illness, or damage or loss to any collateral property. Credit insurance forms and rates must be approved by the Office and Insurance Regulation (OIR).[7] As described below, TILA and Reg Z does not include credit insurance premiums in the finance charge.

The Act provides the grounds for denial of a license of other disciplinary action by the OFR. In particular, s. 516.07(1)(k), F.S, provides that it is grounds for administrative action, for any person to pay money or anything else of value, either directly or indirectly, to any person as compensation, inducement, or reward for referring a loan applicant to a licensed consumer finance lender.

The Act does not apply to persons doing business under state or federal laws governing banks, savings banks, trust companies, building and loan associations, credit unions, or industrial loan and investment companies.[8] As of December 2014, there are 142 licensed consumer finance loan companies operating in 349 locations in Florida.[9]

The OFR also has regulatory authority over other small consumer loans authorized under ch. 520 (retail installment sellers), ch. 537 (title loans), and part IV of ch. 560 (deferred presentment or payday loans), F.S.:

- *Title lenders* provide loans secured through transfer of a motor vehicle certificate of title, with the loan amount dependent on the vehicle's value. Title lenders charge tiered interest rates according to principal amount, similar to the Act. The maturity date of a title loan is 30 days after the agreement date, but the loan can extended for one or more 30-day periods by mutual consent of the lender and the borrower.[10] One major difference between consumer finance loans and title loans is that title lenders are prohibited from selling or charging for any type of insurance in connection with a title loan.[11]
- *Retail installment lenders* under ch. 520, F.S., authorizes retail installment businesses, motor vehicle sellers, and home improvement businesses to finance personal, family, or household goods or services sold by an installment contract or a revolving charge account to a retail buyers.[12] Finance charges under ch. 520, F.S., are expressed in dollar amounts (e.g., $12 per $100 per year for retail installment contracts).[13]
- *Deferred presentment or payday lenders* under part IV of ch. 560, F.S., offer currency or a payment instrument (e.g., electronic funds transfer, check, or money order) in exchange for a person's paycheck up to $500 and agree to hold it for a specified period. Repayment terms range from 7 to 31 days, and the maximum allowable fees is 10% of the currency or payment instrument provided, as well as a verification fee of up to $5.00 per transaction. Borrowers may have only one active payday loan at a time, but are permitted to secure a new loan 24 hours after paying off the original loan.[14]

Current law does not require any underwriting or determination of the borrower's ability to repay for any of these loans. Additionally, retail installment loans and consumer finance loans are excluded from the 18 percent per year simple interest cap set forth in the usury statute.[15] There is no minimum or maximum loan term. However, every loan made pursuant to ch. 516, F.S., except for lines of credit, is to be repaid in monthly installment as nearly equal as mathematically practicable. Each location of a

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[6] s. 516.35, F.S.; see also pt. IX, ch. 627, F.S. (Credit Life and Disability Insurances).
[7] ss. 627.682 and 627.6785, F.S. Credit insurers must meet specified loss ratios for credit life and credit disability insurance. Rules 69O-163.009 - 69O-163.011, Fla. Admin. Code.
[8] s. 516.02(4), F.S.
[9] Office of Financial Regulation, *Fast Facts* (2nd edition, Dec. 2014), http://flofr.com/StaticPages/documents/FastFacts2015.pdf.
[10] s. 537.011(3), F.S.
[11] s. 537.013(1)(h), F.S.
[12] Pts. I, II, and IV, ch. 520, F.S.
[13] s. 520.34(6)(a), F.S.
[14] s. 560.404(6) and (8), F.S.; Rule 69V-560.801, F.A.C.
[15] s. 687.02, F.S.

consumer finance company is required to hold a consumer finance license. Current law does not require reports to be issued by the OFR regarding consumer finance loans.

Federal Regulation of Consumer Lending

Truth in Lending Act and Regulation Z

The purpose of TILA and Reg Z is to promote the informed use of credit through "a meaningful disclosure of credit terms so that the consumer will be able to compare more readily the various credit terms available to him."[16] As mentioned above, TILA and Reg Z requires the calculation and disclosure of Annual Percentage Rate (APR) for all consumer loans.[17] TILA does not include premiums for credit life, accident, or health insurance when calculating the loan's finance charge, as long as the insurance products are voluntary, the lender tells borrower in writing that these products are voluntary, and the borrower consents in writing.[18]

Consumer Financial Protection Bureau

On July 21, 2010, the federal Dodd-Frank Wall Street Reform and Consumer Protection Act (Pub.L. 111-203, H.R. 4173, commonly referred to as "Dodd-Frank") was signed into law. It has widely been described as the most expansive financial regulatory legislation since the 1930s, and was formed with the intent "to focus directly on consumers, rather than on bank safety and soundness or on monetary policy."[19] Title X of Dodd-Frank created the Consumer Financial Protection Bureau (CFPB) as an independent bureau housed within the Federal Reserve System, and reassigned most general rulemaking authority of TILA to the CFPB effective July 21, 2011. Dodd-Frank also:

- Assigned the CFPB broad authority to examine and enforce consumer protection regulations over all mortgage-related businesses, large non-bank financial companies, and banks and credit unions with assets greater than $10 billion. In essence, Dodd-Frank makes the CFPB the primary regulator over non-depository lenders.
- Consolidated and transferred most federal consumer financial protection authority under the CFPB's jurisdiction.[20]
- Granted enforcement and rulemaking authority to the CFPB to protect consumers from unfair, deceptive, or abusive acts or practices under federal law in connection with consumer financial products or services.[21] The CFPB is also authorized to write rules to ensure consumers receive full, accurate, and effective disclosures relating to consumer financial products and services.[22]

Title XII of Dodd-Frank, titled "Improving Access to Mainstream Financial Institutions,"[23] which authorizes the Secretary of the Treasury to establish a multiyear program of grants, cooperative and financial agency agreements, and similar contracts to promote expanded access to mainstream financial institutions and low-cost alternatives to small dollar loans. Title XII also authorizes grants and

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[16] 15 U.S.C. §1601(a).
[17] 15 U.S.C. §§ 1604 – 1606.
[18] 15 U.S.C. §1605(b).
[19] CONSUMER FINANCIAL PROTECTION BUREAU, *Creating the Consumer Bureau*, at http://www.consumerfinance.gov/the-bureau/creatingthebureau/ (last visited Jan. 26, 2016).
[20] Dodd-Frank required the Secretary of the U.S. Treasury to establish a designated transfer date by which the CFPB would receive certain rulemaking, supervision, and enforcement powers from seven existing federal agencies. The Treasury Secretary established July 11, 2011, or one year after the enactment of Dodd-Frank, as the designated transfer date. *See* 75 FR 57272 (Sept. 20, 2010) and 76 FR 43569 (July 21, 2011).
[21] 12 U.S.C. §5531.
[22] 12 U.S.C. §5532.
[23] 12 U.S.C. subchapter VII. "The purpose of th[e] subchapter is to encourage initiatives for financial products and services that are appropriate and accessible for millions of American who are not fully incorporated into the financial mainstream." 12 U.S.C. § 5621.

financial assistance to help community development financial institutions to establish and maintain small dollar loan programs.[24]

Additionally, the CFPB is considering proposed rules on payday lending, focusing on stricter underwriting requirements (including borrowers' ability to repay), rollovers, an "off-ramp" for repaying the debt, and restricting lenders' access to a borrower's checking account, pursuant to its authority under Dodd-Frank. The CFPB's proposals would establish a federal floor or minimum for consumer protection for "covered loans," which could include payday loans, deposit advance products, vehicle title loans, high-cost installment loans, open-end lines of credit and other loans.[25] It appears that the CFPB's proposed rules will address loopholes in various state lending laws.[26]

However, Dodd-Frank does not authorize the CFPB to establish interest rate limits for extensions of credit, so any adjustments to interest rates for payday loans must be addressed by the states in which they are offered.

California Small Dollar Loan Pilot Programs

Based on a business model developed by California-based Progreso Financiero (Progress Financial), the California State Assembly enacted the Affordable Credit Building Opportunities Pilot Program in 2010, placing it under its state finance lenders law. The goal was to increase consumers' access to capital by encouraging development of a more robust small dollar loan market in California. Due to a low lender participation rate, it was replaced by a 2013 pilot program which will remain in effect until January 1, 2018, unless extended by its state legislature and governor.

The revised California pilot program also allows the use of "finders" to connect borrowers with lenders. Finders cannot provide advice or counseling to borrowers. They can distribute lenders' marketing materials, provide factual information about loan terms and conditions, help borrowers with loan applications and obtain borrowers' signatures on documents, among other functions. Their fees are capped at $45 or $40, depending on the number of loans they originate in a month. The fees are paid by lenders, cannot be based on the principal amount of loans, and cannot be passed on to borrowers.

According to the California State Assembly staff analysis, the proponents view the use of finders as a way to lower costs of customer acquisition, which is the largest cost of maintaining a low dollar value loan program. Prior to the 2010 enactment of the bill, Progreso Financiero used word-of-mouth and booths inside supermarkets to attract potential customers and tested direct mail. The use of finders was intended to act in the same way a retail clerk acts a department store when he or she offers a customer the opportunity to apply for a store-branded credit card. If the customer accepted, the retail clerk or finder collects preliminary information at the point of sale and conducts a prequalification check.[27]

The California pilot program legislation also required the state's Department of Business Oversight (DBO) to post a report summarizing findings of the pilot program. In June 2015, the California DBO's report noted the following findings from 2011-2014:

- *Lender participation*: The DBO received 13 applications, and approved 6. At the end of 2014, 6 lenders and 6 finders participated in the program.

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[24] "Community development financial institutions" must be depository institutions (such banks and credit unions) which meet the definition and criteria in 12 U.S.C. §2702(5).

[25] CONSUMER FINANCIAL PROTECTION BUREAU, *CFPB Considers Proposal to End Payday Debt Traps*, http://www.consumerfinance.gov/newsroom/cfpb-considers-proposal-to-end-payday-debt-traps/ (last visited Jan. 29, 2016).

[26] Jeff Guo, *Many states have cracked down on payday loans. Here's how lenders still get away with it*, THE WASHINGTON POST (Feb. 9, 2015), http://www.washingtonpost.com/blogs/govbeat/wp/2015/02/09/many-states-have-cracked-down-on-payday-loans-heres-how-lenders-still-get-away-with-it/ (last visited Jan. 29, 2016).

[27] California Senate Committee on Banking, Finance, and Insurance, Bill Analysis of SB 1146, on file with the Insurance & Banking Subcommittee staff.

- *Loan applications*: Borrower applications increased by 58.5 percent after the state revised the pilot program.
- *Dollar amounts*: Smaller loans ($300-$499) decreased by 42.3 percent, while larger loans ($500-$999) increased by 106 percent.
- *Interest rates:* Smaller loans generally carried an APR of 40-50 percent. Mid-range loans generally carried an APR of 35-50 percent. Larger loans ($1,500-$2,499) saw a more even APR distribution.
- *Delinquency rates*: In 2014, 22.5 percent were delinquent for seven days to 29 days, 7.3 percent were delinquent for 30 days to 59 days, and 3.9 percent were delinquent for 60 days or more.
- *Multiple loans*: The number of borrowers who took out more than one loan jumped dramatically from 2011 to 2012, but has since stabilized.
- *Credit scores*: The share of multiple-loan borrowers who obtained higher credit scores on subsequent loans averaged 61 percent annually over the four-year period.
- *Loan term:* In 2014, of the 164,300 loans made, 50.9 percent were for 360 days or more. The ratios for other terms: 120 days to 179 days, essentially 0 percent (only two loans); 180 days to 269 days, 20.2 percent; and 270 days to 359 days, 28.8 percent.
- *Loan purpose:* Of the 164,300 loans made in 2014, borrowers took out 45 percent (74,026) to build or repair credit. Ratios for other purposes: medical or other emergency, 18.4 percent; pay bills, 12.7 percent; consolidate debt, 5.7 percent; non-vehicle purchase, 5.3 percent; vehicle purchase, 2.7 percent; vehicle repair, 2.6 percent; other than personal or household purpose, 1.1 percent; other, 6.4 percent.
- *Number and types of violations found during examinations*: The DBO generally found very few pilot program violations and no violations on finders in the examination process. In 2013, it found instances where borrowers were not asked about outstanding payday loans, credit performance was not reported to a credit agency, and the borrower was not provided with a notice of rescission rights.

The California DBO noted that while the revised pilot program did increase lender participation from its inception in 2010, the total number of participating lenders remains less than 10. Additionally, the revisions did not significantly affect the amount of lending activity conducted by the individual companies.[28]

Oportun, formerly known as Progreso Financiero, was founded in 2005 to provide credit-building affordable loans to financially-underserved Hispanics in the U.S. Currently, Oportun operates more than 170 locations in California, Illinois, Nevada, Texas, and Utah.[29] In 2012, Oportun's founder founded INSIKT, a white label loan origination and investing platform that uses scoring and loan syndication technology to lend to customers and any accredited investor to invest in consumer loan portfolios. In 2015, California enacted legislation, backed by INSIKT, to increase access to the small-dollar loans.[30] INSIKT now seeks to implement similar small dollar loan pilot programs in other states, including Florida.

Effect of the Bill

The bill establishes a pilot program entitled Increased Access to Responsible Small-Dollar Loans Pilot Program ("program.") The program would allow consumers to enter into a "small loan" with a principal amount of at least $300 up to a maximum of $3,000, at a fixed interest rate not to exceed 36 percent per annum calculated by simple interest, for a term of not less than 90 days. Under current law,

[28] California Department of Business Oversight, Report of Activity under Small Dollar Loan Pilot Programs (Jun. 2015), at http://www.dbo.ca.gov/Licensees/Finance_Lenders/pdf/Pilot%20Program%20Report%202015%20Final.pdf.
[29] OPORTUN, *About Us: Background*, at http://www.oportun.com/about-progreso/ (last visited Jan. 29, 2016).
[30] PRWEB, *Governor Brown Signs Financial Lending Bill Aimed at Underserved Communities*, at http://www.prweb.com/releases/2015/10/prweb13000745.htm (last visited Jan. 29, 2016).

licensed consumer finance lenders may make loans in this amount at a maximum rate of 30 percent, with no minimum or maximum loan term.

Licensing Requirements

A small loan license is required in order to impose any charge or fees or use a referral partner, and may be issued for more than one location in this state if the licensee offers and accepts loan aplications only through its website. The bill also requires applicants to be a "data furnisher" with a consumer reporting agency[31] at the time of application, meaning a creditor that furnishes information to a consumer reporting agency. However, the bill allows the OFR to issue a small loan license if the OFR "reasonably believes" that the applicant will qualify as a data furnisher within 6 months after receiving a license, and the OFR must revoke a license if the applicant fails to do so.

The bill also provides that licensing fees shall be in an amount necessary to cover the expenses of administering this section.

Small Loan Requirements

The bill establishes the following requirements for a "small loan":

- Principal amount between $300 to $3,000;
- Must have a term of 90 days or longer;
- Must be unsecured;
- Maximum interest rate of 36 percent per annum, fixed for the life of the loan; must be calculated by simple interest and not add-on interest or other computations;
- Small loans are subject to s. 516.031(5), F.S., which limits the amount of unpaid interest that may be included in the principal amount payable on a refinanced loan.
- *Origination fees* are allowed, but only once at the closing of the loan, and cannot be imposed more than once in any 4-month period:
    - On the borrower's first loan, the origination fee may not exceed the lesser of 7 percent of principal or $90.
    - On subsequent loans or refinances, the origination fee may not exceed the lesser of 6 percent of principal or $75.
- *Delinquency charges* are allowed, up to $14 for each payment in default for at least 7 days. Only one delinquency charge is allowed per delinquent payment, and no more than two delinquent charges may be imposed during a period of 30 consecutive days.
    - It is unclear how a delinquent charge could be imposed more than once in a monthly period. Section 516.36, F.S., requires all loans made under the Act be repaid in monthly installments as nearly equal as mathematically possible.
- *Minimum collection period* – the bill requires licensees to attempt to collect a delinquent payment for a period of at least 30 days after the due date, before selling or assigning the unpaid debt to an independent party for collection.
    - This provision may create confusion for borrowers, who could be charged delinquency fees for a payment that is at least 7 days late, and who may attempt to send payment to the lender while the loan is being assigned or transferred.[32]
- *Bad check (NSF) charges* of up to $25 are allowed.
- The sale of *credit insurance* in connection with a small loan is prohibited.

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[31] The bill defines "consumer reporting agency" as the same definition in federal Fair Credit Reporting Act: "[A]ny person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties, and which uses any means or facility of interstate commerce for the purpose of preparing or furnishing consumer reports."

[32] The Florida Consumer Collection Practices Act (pt. VI, ch. 559, F.S.) applies to the collection of consumer debts in Florida. Section 559.715, F.S., does not prohibit creditors from assigning the right to bill and collect a consumer debt. However, the assignee must give the debtor written notice of such assignment as soon as practical after the assignment is made, but *at least 30 days* before any action to collect the debt.

- Before loan proceeds are disbursed, licensee must offer the borrower *consumer credit counseling* pursuant to s. 516.32, F.S., which is approved by the OFR or may invite the borrower to a program offered by an independent third party. However, the licensee cannot require borrower to attend either program and must provide the counseling at no cost.
- *Credit Reporting* - the bill requires small loan licensees to report all borrower payments to a consumer reporting agency. A licensee who becomes a data furnisher for a consumer reporting agency must report all payments to the data furnisher as soon as practicable.
- *Underwriting* - the bill prohibits small loan licensees from lending to borrowers with debt-to-income ratios greater than 50 percent. The bill also defines "debt" and "income," and excludes loans from friends and family from "debt." It is unclear how this debt to income ratio is determined.
- *Waivers* – the bill provides that licensees cannot require prospective borrowers to waive his/her legal rights to obtain a loan unless with express informed consent. Waiver without informed consent is void, but does not affect the validity or enforceability of other provisions of the loan agreement.

Disclosures

The bill requires licensees to deliver a statement pursuant to s. 516.15(1), F.S., which requires:

- The amount and date of the loan and date of its maturity;
- The nature of the security, if any (inapplicable to small loans because they must be unsecured);
- The name and address of the borrower and of the licensee; and
- The rate of interest charged.

In addition, the bill requires the statement to include the following in 12-point type:

- The periodic payment amount;
- The delinquency fee amount;
- A statement regarding the benefits of early payoff, and that there is no prepayment penalty;
- A statement regarding the borrower's rescission rights;
- The name of the consumer reporting agency to which the licensee will report the borrower's payment history; and
- If the borrower submitted a loan application to a referral partner, a statement identifying the lender and contact information, as well as the OFR's contact information if the borrower has a complaint against a referral partner or licensee.

Receipts

The bill requires the small loan licensee and referral partner to provide a receipt to borrower for each payment made on account of the loan, or else forfeit the entire interest on the principal.[33] The receipt must contain:

- Name of the referral partner, if applicable;
- Total payment received;
- Date of payment;
- Loan balance before and after payment;
- The amount of payment applied to principal, interest, and fees;
- Form of payment; and
- A statement that directs borrowers to the licensee and licensee's contact information, if the borrower has questions about the loan.

[33] s. 687.08, F.S., sets forth a similar requirement for receipts.

Referral Partners

The bill allows small loan licensees to contract with one or more referral partners to:

- Distribute marketing materials and other written information related to small loans;
- Assist prospective borrowers in completing a loan application and update the prospective borrower on the status of the loan application;
- Submit the loan applications to the licensee. The referral partner may only submit a loan application to one licensee. If the licensee declines to offer a loan to a prospective borrower, the referral partner may submit the loan application of that prospective borrower to another licensee;
- Inform borrowers of the terms of the loan;
- Close the loan transaction on behalf of the licensee and disburse the loan proceeds to the borrower; and
- Receive loan payments from a borrower.

However, the bill prohibits referral partners from:

- Providing counseling or advice to borrowers; or
- Negotiating the terms of the loan on behalf of the licensee or borrower.

The bill requires licensees to preapprove referral partners' marketing materials, written materials, and loan information. The bill prohibits licensees from consummating a loan until all of the borrower's questions are answered. If a licensee contracts with a referral partner, the licensee must notify the OFR within 15 days of the contract, and must include specified items such as contact information and any other information requested by the OFR.

As agents of small loan licensees, referral partners must comply with the Act and all applicable rules of the OFR. Small loan licensees would be allowed compensate referral partners unless loan is consummated, up to $60 per loan and up to $2 per loan payment received by the referral partner. Licensees cannot pass referral fees onto borrowers and the compensation cannot be based on the principal amount of the loan.

OFR Enforcement Authority

- *Recordkeeping* – the bill requires small loan licensees and referral partners to maintain books, accounts, and records per s. 516.12, F.S.
- *Examinations* – the bill requires OFR to examine a license and referral partners pursuant to s. 516.11, F.S., at least once every 24 months, which the OFR can waive if it determines is not necessary for the protection of the public. Additionally, the OFR would be required to randomly survey borrowers as part of exam process. Licensees must reimburse OFR for cost of exams, and the OFR may recover costs in any court of competent jurisdiction.
- *Enforcement* – the bill subjects small loan licensees and referral partners to the OFR's enforcement provisions of s. 517.07(2), F.S. Licensees are also held responsible for violations committed by their referral partners. Although the bill appears to subject referral partners to administrative action pursuant to s. 516.07, F.S., by the OFR, some of the grounds in s. 516.07, F.S., do not directly apply to referral partners. For example, the statute allows the OFR to deny or revoke licenses for material misstatements of fact in an application or failure to maintain at least $25,000 in liquid assets, which apply only to the lender licensee.

Reports by Licensees and the OFR

The bill requires licensees to file with OFR by March 15, 2017, and annually thereafter, a report in the manner prescribed by the OFR related to its small loans.

By January 1, 2018, and annually thereafter, the OFR must publish its program report online. The report may not identify data by any specific licensee, but must include 20 aggregate data points, such as the number of applicants for the pilot program, number of borrowers who obtains loans for certain purposes, the number and type of referral partners used by licensees, delinquency data, and recommendations for improving the pilot program.

The bill provides an effective date of July 1, 2016, and provides that the pilot program expires on January 1, 2022.

B. SECTION DIRECTORY:

Section 1. Creates s. 516.40, F.S., relating to the Increased Access to Responsible Small-Dollar Loans Pilot Program.

Section 2. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Indeterminate. The bill provides for new application fees (of indeterminate amount) and examination fees paid by small loan licensees. It is unknown how many applicants and licensees will participate in this pilot program.

2. Expenditures:

   - OFR resources will be required to process applications; process complaints; examine records of program licensees and referral partners; and, if necessary, initiate enforcement actions for non-compliance or fraud. The state of California currently has a total of eight program licensees. Assuming a comparable number of businesses apply to become a program licensee, the Division of Consumer Finance believes it can absorb the workload associated with the above-mentioned tasks. However, the OFR will reassess its funding needs based on volume of activity for this new program and may request additional funding in future fiscal years.
   - Additionally, the bill will require updates to the OFR's licensing and examination software as well as information technology support and increased data storage to integrate applications by program licensees. The bill would likely require the OFR to create electronic forms for applications and reporting. The bill would require the OFR to post on its website a report that includes extensive information regarding the pilot program. Implementing such changes would cost the agency approximately $116,650.
   - In the bill's requirement that the OFR post an annual report, the bill directs the OFR to include "[c]omparable delinquency data for unsecured loans made under this chapter and by state-chartered banks and credit unions for principal loan amounts of at least $300 but not more than $3,000." Such data is not readily available. Inclusion of such information would be burdensome, and the cost of efforts to gather such data has not been taken into account in composing the fiscal impact of this legislation.
   - The OFR would incur insignificant costs associated with rulemaking.[34]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

[34] OFR Agency Analysis, pp. 7-8.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. The number of lenders, referral partners, and borrowers who participate in this pilot program cannot be projected.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill requires the Financial Services Commission to amend existing rules. The OFR recommends an effective date of no earlier than January 1, 2017 to allow sufficient time for rulemaking.[35]

C. DRAFTING ISSUES OR OTHER COMMENTS:

- The bill requires applicants to be a data furnisher at the time of application, but allows licenses to be issued if the OFR "reasonably believes" that the applicant will qualify as a data furnisher within 6 months *after* issuance of the license. This is contrary to the licensing provision in the Administrative Procedure Act, s. 120.60(1), F.S., which sets forth uniform timeframes and procedures for state agencies in processing applications for licensure. Specifically, an application is deemed "complete" upon receipt of all requested information and correction of all deficiencies for which the applicant was timely notified. This is critical for triggering the general 90-day timeframe for agencies to approve or deny an application for a license and thus provide a point of entry into administrative proceedings for an applicant if necessary.
- The bill is silent as to the OFR's authority to deny applications for small loan licenses, compared to the OFR's current authority to deny consumer finance licenses under the Act in s. 516.07, F.S., which includes disqualifers such as material misstatements of fact in an application for a license and certain criminal background events.
- The bill allows the OFR to examine the books and records of licensees and referral partners. Currently, there is no public records exemption for examination records under the Act. Pursuant to ch. 119, F.S., records held by an agency are public records, unless expressly exempted. Given that the bill requires lenders to conduct underwriting and to comply with certain requirements not in the current Act, small loan licensees and referral partners will necessarily possess sensitive borrower information and possibly proprietary business information that would be subject to examination by the OFR. Currently, only limited exemptions in ch. 119, F.S., would protect social security numbers, bank account numbers and debt, charge, and credit card numbers held by an agency.[36] However, art. I, s. 24(c) of the state Constitution requires a separate public records bill be introduced and meet specified constitutional requirements, such as two-thirds vote of the members present and voting for final passage of a newly created public

[35] OFR Agency Analysis, p. 8.
[36] s. 119.071(5)(a)5. and (b), F.S.

records exemption, a public necessity statement, and an exemption that is no broader than necessary to accomplish the stated purpose of the law.

Additionally, the OFR provided the following comments:

- The bill directs the OFR to randomly survey borrowers as part of its examination of licensees and referral partners, and to then include the survey results in the annual report that the OFR is to post on its website. The legislation also directs the OFR to include in that annual report "recommendations for improving the pilot program and recommendations regarding whether the program should be continued." These tasks appear contrary to the OFR's role as a regulator.
- The bill would allow the OFR to revoke approval for a licensee's participation in the program if the small loan licensee fails to meet a certain requirement. Such language conflicts with the provisions in S. 120.60, F.S., which mandates that an agency must provide notice and an opportunity to request a hearing when an agency attempts to withdraw a license. Additionally, the language of the bill is silent as to what happens to loans held by program licensees once withdrawal has taken place.

The OFR also posed the following questions:

- Will the small loan licensee have to determine if a borrower resides in a low-income census tract, or is this an agency function?
- Under the proposed language in s. 516.40, F.S., would the prohibition against secured loans, apply to the holding of a borrower's personal check?
- The proposed language in s. 516.40, F.S., does not address the amounts included in a rescission. Is the entire loan rescinded, or would such rescission only apply to the loan proceeds? Are the origination fees considered earned, or are such fees rescinded, as well?
- Would this pilot program allow a borrower to take out multiple loans at the maximum ($3,000) amount simultaneously, perhaps from more than one small loan licensee?
- The legislation requires a licensee to offer free consumer credit counseling services provided by the OFR or credit education programs offered by an independent third party to a prospective borrower during the loan application process, but the OFR does not currently offer consumer credit counseling services. Is the expectation of this legislation that the OFR would need to create such a free program?[37]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

It is anticipated that the sponsor will file a strike-all amendment, based on the Senate companion bill, SB 1696, with additional changes.

[37] OFR Agency Analysis, pp. 8-9.

1 A bill to be entitled
2 An act relating to consumer finance; creating s.
3 516.40; creating the Increased Access to Responsible
4 Small-Dollar Loans Pilot Program within the Office of
5 Financial Regulation; providing definitions; requiring
6 persons charging fees or using referral partners under
7 the pilot program to obtain a license; providing
8 licensing requirements; providing fee requirements;
9 providing conditions and requirements for small loan
10 licensees; providing loan requirements; providing
11 disclosure requirements; providing requirements
12 related to loan payment receipts; authorizing a small
13 loan licensee to contract with a referral partner for
14 certain purposes; regulating the activities and
15 compensation of referral partners; providing
16 recordkeeping requirements; requiring the office to
17 examine licensees and referral partners; requiring
18 licensees to reimburse the office for examination
19 costs; providing grounds for disciplinary action;
20 providing reporting requirements; providing for
21 expiration of the pilot program; providing an
22 effective date.
23
24 Be It Enacted by the Legislature of the State of Florida:
25
26 Section 1. Section 516.40, Florida Statutes, is created to

27 read:
28 516.40 Increased Access to Responsible Small-Dollar Loans
29 Pilot Program.—
30 (1) There is created within the Office of Financial
31 Regulation the Increased Access to Responsible Small-Dollar
32 Loans Pilot Program. The purpose of the program is to fulfill
33 consumer demand for loans with a principal amount of $3,000 or
34 less and improve consumers' credit ratings through these
35 installment loans.
36 (2) DEFINITIONS.—As used in this section, the term:
37 (a) "Borrower" means a person who incurs either direct or
38 contingent liability to repay a small loan.
39 (b) "Consumer reporting agency" has the same meaning as
40 provided in 15 U.S.C. s. 1681a(p).
41 (c) "Credit score" has the same meaning as provided in s.
42 626.9741.
43 (d) "Data furnisher" means a creditor that furnishes
44 information to a consumer reporting agency.
45 (e) "Pilot program" means the Increased Access to
46 Responsible Small-Dollar Loans Pilot Program.
47 (f) "Referral partner" means a person who directly or
48 indirectly solicits or offers to solicit a small loan and
49 accepts or offers to accept an application for a small loan. A
50 referral partner is not a loan broker as defined in s. 687.14 or
51 a credit service organization as defined in s. 817.7001.
52 (g) "Small loan" means a loan made pursuant to this

53 section.
54 (h) "Small loan license" or "license" means a license
55 issued under this section to provide small loans.
56 (i) "Small loan licensee" or "licensee" means a person to
57 whom a small loan license is issued.
58 (3) SMALL LOAN LICENSE; FEES.—A person may not impose any
59 charges or fees or use a referral partner pursuant to this
60 section without a valid small loan license. A person may apply
61 for and obtain a small loan license pursuant to ss. 516.03 and
62 516.05, with the following exceptions:
63 (a) A small loan license may be issued for more than one
64 physical location if the licensee offers and accepts loan
65 applications only through its website.
66 (b) An applicant must be a data furnisher with a consumer
67 reporting agency at the time of application. However, the office
68 may issue a small loan license to an applicant if the office
69 reasonably believes that the applicant will qualify as a data
70 furnisher within 6 months after receiving a small loan license.
71 If the applicant fails to become a data furnisher within 6
72 months after receiving a license, the office must revoke the
73 small loan license.
74 (c) The small loan license fee shall be an amount
75 necessary to cover the expenses of administering this section.
76 (4) SMALL LOANS.—A small loan licensee must comply with
77 this chapter unless otherwise specifically provided by this
78 section.

79 (a) A small loan licensee must offer consumer credit
80 counseling services provided by the office or credit education
81 programs offered by an independent third party to a prospective
82 borrower during the loan application process. Such educational
83 programs shall be provided to a prospective borrower free of
84 charge. Attendance of such a program is not a condition of
85 obtaining a small loan.
86 (b) A small loan licensee must report all payments from a
87 borrower to a consumer reporting agency. A licensee that becomes
88 a data furnisher for a consumer reporting agency must report all
89 payments from a borrower to the data furnisher as soon as
90 practicable.
91 (c) The licensee must attempt to collect a delinquent
92 payment for a period of at least 30 days after the date that
93 payment is due before selling or assigning the unpaid debt to an
94 independent party for collection.
95 (d) A licensee may not make a loan to a prospective
96 borrower with a debt-to-income ratio greater than 50 percent. As
97 used in this paragraph, the term:
98 1. "Debt" means total monthly debt service payments,
99 including the small loan being considered, across all
100 outstanding forms of credit. Debt may, but is not required to,
101 include loans from friends or family.
102 2. "Income" means the prospective borrower's gross monthly
103 income.
104 (e) A licensee may not require a prospective borrower to

105 waive his or her legal rights as a condition of obtaining the
106 small loan without the borrower's express informed consent to
107 such waiver. Any waiver made by the borrower without informed
108 consent is void but does not affect the validity or
109 enforceability of other provisions of the loan agreement.
110 (5) FINANCE CHARGE; MAXIMUM RATES.—A small loan licensee
111 may lend any sum of money in the principal amount of at least
112 $300 but not more than $3,000. A small loan must have a term of
113 90 days or longer and must be unsecured. Notwithstanding s.
114 516.031, a licensee may charge, contract for, and receive
115 interest and other charges as provided and authorized by this
116 subsection.
117 (a) The maximum interest rate is 36 percent per annum. The
118 interest must be calculated by simple interest and not add-on
119 interest or any other computations. The interest rate must be
120 fixed for the life of the loan.
121 (b) Section 516.031(5) applies to a small loan that is
122 refinanced.
123 (c) A licensee may contract for and receive an origination
124 fee on a small loan and the refinance of the loan. The fee may
125 only be imposed once at the closing of a loan and may not be
126 imposed more than once in any 4-month period.
127 1. On the first loan made to a borrower, the origination
128 fee may not exceed the lesser of 7 percent of the principal
129 amount or $90.
130 2. On the second or subsequent loan, including a

131 refinanced loan, the origination fee may not exceed the lesser
132 of 6 percent of the principal amount or $75.
133 (d) A licensee may charge and receive a delinquency charge
134 not to exceed $14 for each payment in default for at least 7
135 days. Only one delinquency charge may be imposed per delinquent
136 payment, and no more than two delinquent charges may be imposed
137 during a period of 30 consecutive days.
138 (e) A licensee or referral partner who receives a check,
139 draft, negotiable order of withdrawal, or like instrument drawn
140 on a bank or other depository institution, from a borrower as
141 full or partial repayment of a loan, may make and collect from
142 the borrower a bad check charge of not more than $25 if such
143 instrument is not paid or is dishonored by such institution.
144 (f) A licensee or any other person in connection with the
145 making of a small loan may not offer, sell, or require the
146 borrower to obtain credit insurance on a small loan.
147 (6) DISCLOSURE.—A licensee must deliver a statement
148 pursuant to s. 516.15(1) to the borrower in at least 12-point
149 type. The statement may be provided electronically to the
150 borrower if the borrower has the option to print the statement
151 in at least 12-point type. The statement must include:
152 (a) The periodic payment amount.
153 (b) The delinquency fee amount.
154 (c) The following statement: "Repaying your loan early
155 will lower your borrowing costs by reducing the amount of
156 interest you will pay. This loan has no prepayment penalty."

157 (d) The following statement: "The borrower has the right
158 to rescind the loan by notifying the licensee and returning the
159 principal advanced by the end of the business day after the date
160 the loan proceeds are disbursed."
161 (e) The name of the consumer reporting agency to which the
162 licensee shall report the borrower's payment history. If the
163 licensee became a data furnisher after the loan is consummated,
164 the licensee shall provide the name of the consumer reporting
165 agency to the borrower as soon as practicable.
166 (f) If the borrower submitted a loan application to a
167 referral partner, the referral partner must provide the
168 following statement to the borrower:
169
170 "Your loan application has been referred to us by
171 ...(name of referral partner).... We may pay a fee to
172 ...(name of referral partner)... for the successful
173 referral of your loan application. IF YOU ARE APPROVED
174 FOR THE LOAN, ...(NAME OF LICENSEE)... WILL BECOME
175 YOUR LENDER. If you have any questions about your
176 loan, now or in the future, you should direct those
177 questions to ...(name of licensee)... by ...(insert at
178 least two different ways in which a borrower may
179 contact the licensee).... If you wish to report a
180 complaint about ...(name of referral partner)... or
181 ...(name of licensee)... regarding this loan
182 transaction, you may contact the Florida Office of

183 Financial Regulation at ...(telephone number)...."
184
185 (7) RECEIPTS.—A licensee and a referral partner must
186 provide the borrower, at the time that payment is made, with a
187 plain and complete receipt for each payment made on account of
188 any loan. A licensee or referral partner who refuses, upon
189 demand, to give a receipt complying with this subsection
190 forfeits the entire interest upon such principal sum to the
191 borrower. A receipt for payment must contain:
192 (a) The name of the referral partner, if applicable.
193 (b) The total payment amount received.
194 (c) The date of payment.
195 (d) The loan balance before and after application of the
196 payment.
197 (e) The amount of the payment that is applied to
198 principal, interest, and fees.
199 (f) The form of payment, such as cash, check, or money
200 order.
201 (g) If the payment is received by a referral partner, the
202 following statement: "If you have any questions about your loan
203 now or in the future, you should direct those questions to
204 ...(name of licensee)... by ...(insert at least two different
205 ways in which a borrower may contact the licensee)...."
206 (8) REFERRAL PARTNERS.—
207 (a) A small loan licensee may contract with one or more
208 referral partners to:

209 1. Distribute marketing materials and other written
210 information related to small loans.
211 2. Assist prospective borrowers in completing a loan
212 application and update the prospective borrower on the status of
213 the loan application.
214 3. Submit the loan applications to the licensee. The
215 referral partner may only submit a loan application to one
216 licensee. If the licensee declines to offer a loan to a
217 prospective borrower, the referral partner may submit the loan
218 application of that prospective borrower to another licensee.
219 4. Inform borrowers of the terms of the loan.
220 5. Close the loan transaction on behalf of the licensee
221 and disburse the loan proceeds to the borrower.
222 5. Receive loan payments from a borrower.
223 (b) A referral partner may not:
224 1. Provide counseling or advice to the prospective
225 borrower.
226 2. Negotiate the terms of the loan on behalf of the
227 licensee or the prospective borrower.
228 (c) All marketing materials, written materials, and loan
229 information provided by a referral partner must be prepared by
230 the licensee or preapproved by the licensee. The licensee must
231 be available to answer any questions that a prospective borrower
232 has related to a small loan. The loan cannot be consummated
233 until the borrower's questions are answered.
234 (d) A referral partner is an agent of the licensee and

235 must comply with this section and all applicable rules of the
236 office.
237 (e) The licensee may compensate a referral partner for its
238 services, subject to the following requirements:
239 1. A referral partner may not be compensated in connection
240 with a loan application unless the loan is consummated. The
241 compensation may not exceed $60 per loan.
242 2. A referral partner may not be compensated more than $2
243 per loan payment received by the referral partner.
244 3. Compensation to a referral partner may not be based on
245 the principal amount of the loan.
246 4. A licensee may not directly or indirectly charge a
247 borrower any fee or expense incurred by the licensee related to
248 the loan.
249 (e) If a licensee enters into a contract with a referral
250 partner, the licensee must notify the office within 15 days
251 after entering into the contract on a form prescribed by the
252 office. The form must include the following information:
253 1. The name, business address, and licensing details of
254 the referral partner and all locations at which the referral
255 partner will perform services under this section.
256 2. The name and contact information for the person who
257 executed the referral partner agreement on behalf of the
258 referral partner.
259 3. The name and contact information for at least one
260 employee of the referral partner carrying out the terms of the

261 agreement.
262 4. Any other information requested by the office.
263 (9) RECORDS.—A small loan licensee and a referral partner
264 must maintain books, accounts, and records as provided in s.
265 516.12.
266 (10) INVESTIGATIONS.—The office shall examine a licensee
267 and its referral partners as provided in s. 516.11 at least once
268 every 24 months to determine compliance with this section. The
269 office may waive the examination of one or more locations of the
270 licensee if the office determines that the examination of that
271 location is not necessary for protection of the public.
272 (a) The office shall randomly survey borrowers as part of
273 its examination of licensees and referral partners.
274 (b) A licensee shall reimburse the office for the cost of
275 examining the licensee and its referral partners. The office may
276 bring an action in any court of competent jurisdiction against a
277 licensee to recover the cost of examination of the licensee and
278 its referral partners. In determining the cost of the
279 examination, the office may use the estimated average hourly
280 cost for all persons performing examinations of licensees or the
281 licensee's referral partner.
282 (11) GROUNDS FOR DISCIPLINARY ACTION.—A small loan
283 licensee or a referral partner who violates any applicable
284 provision of this chapter is subject to disciplinary action
285 pursuant to s. 516.07(2). A licensee is also subject to
286 disciplinary action for a violation of this section committed by

287 any of its referral partners.
288 (12) REPORTING REQUIREMENTS.-
289 (a) A licensee must file with the office on or before
290 March 15, 2017, and annually thereafter, a report in a manner
291 prescribed by the office related to its small loans.
292 (b) The office must post on its website on or before
293 January 1, 2018, and annually thereafter, a report on the
294 effectiveness of the pilot program. The report may not identify
295 data by specific licensee, but must include:
296 1. The number of applicants for the pilot program.
297 2. The number of entities granted a small loan license.
298 3. The reasons that the office denied an applicant's
299 request to participate in the pilot program.
300 4. The number of applications for a small loan and the
301 number of small loans made.
302 5. The total principal amount of loans made under the
303 pilot program.
304 6. The duration of the loans and loan interest rates.
305 7. The number of borrowers who obtained more than one
306 small loan and the number of loans per borrower.
307 8. The effect of the pilot program on the borrowers'
308 credit score.
309 9. The income distribution of borrowers upon loan
310 origination.
311 10. The number of borrowers who reside in a low-income
312 area.

313 11. The number of borrowers who obtained loans for the
314 following purposes:
315 a. Medical.
316 b. Vehicle repair or purchase.
317 c. Payment of household bills.
318 d. Debt consolidation.
319 e. Building or repairing credit history.
320 f. Other purposes not provided in subparagraphs a.-e.
321 12. The number of borrowers who maintained a bank account
322 at the time of their loan application.
323 13. The number and percentage of borrowers who requested
324 to refinance their small loans and the number and percentage of
325 small loans actually refinanced.
326 14. The number and type of referral partners used by
327 licensees.
328 15. The number and percentage of borrowers who were
329 charged a delinquency fee, the number of days the loans were
330 delinquent, the total amount of delinquency fees charged, and
331 the average delinquency fee assessed by dollar amount and as a
332 percentage of the principal amount loaned.
333 16. Comparable delinquency data for unsecured loans made
334 under this chapter and by state-chartered banks and credit
335 unions for principal loan amounts of at least $300 but not more
336 than $3,000.
337 17. The number and types of violations of this section by
338 licensees and referral partners and disciplinary actions taken

339 by the office against licensees or referral partners.
340 18. The number of complaints received by the office from
341 borrowers against licensees or referral partners and the nature
342 of those complaints.
343 19. Results of surveys completed by borrowers relating to
344 their experience with the pilot program.
345 20. Recommendations for improving the pilot program and
346 recommendations regarding whether the program should be
347 continued.
348 (13) This section expires January 1, 2022.
349 Section 2. This act shall take effect July 1, 2016.

INSURANCE & BANKING SUBCOMMITTEE

HB 1425 by Rep. Fant
Consumer Finance

AMENDMENT SUMMARY
February 1, 2016

Amendment 1 by Rep. Fant (strike-all): Replaces the bill with the Senate companion (SB 1696), which differs from the House bill in the following ways:

- Provides more specific disclosure requirements in loan agreements,
- Prohibits choice of law clauses and loan agreements that condition the loan on the borrower's waiver of certain rights, and provides that such waivers are presumed to be against public policy and unenforceable,
- Requires licensees to determine the borrower's ability to repay and to obtain documentation to verify income,
- Allows delinquency charges only if the licensee and borrower first agree to the charge in writing, and
- Provides a more detailed definition of "referral partner" and more detailed list of permissible and prohibited activities.

The strike-all amendment also clarifies that:

- Except as provided by the bill, licensees are subject to the Act, including the administrative enforcement provisions,
- Referral partners are subject to examination by the OFR,
- The scope of examinations and investigations conducted by the OFR is limited in that licensees must provide only aggregated or anonymized information to the OFR that excludes proprietary and trade secret information, and
- Clarifies that licensees must report aggregate data to the OFR without reference to their proprietary or trade secret information, in addition to borrowers' nonpublic personal information.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

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1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Fant offered the following:
4
5 **Amendment 1 (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Section 516.40, Florida Statutes, is created to
8 read:
9 516.40 Access to Responsible Credit Pilot Program.—
10 (1) There is created within the Office of Financial
11 Regulation the Access to Responsible Credit Pilot Program.
12 (2) The Legislature finds that demand for responsible
13 consumer finance installment loans in principal amounts of at
14 least $300 and no more than $3,000 exceeds the supply of these
15 loans. As a first step toward addressing this gap, the Access to
16 Responsible Credit Pilot Program would allow more Floridians to
17 obtain responsible consumer finance installment loans of at

18 least $300 and no more than $3,000. The pilot program is also
19 intended to assist consumers in building their credit and has
20 additional consumer protections for these installment loans
21 which exceed current protections under general law.
22 (3) Except as otherwise provided, ss. 516.40-516.47 do not
23 exempt a licensee from any other provision of this chapter.
24 Section 2. Section 516.41, Florida Statutes, is created to
25 read:
26 516.41 Definitions.—As used in ss. 516.40-516.47, the
27 term:.—
28 (1) "Consumer reporting agency" has the same meaning as
29 provided in s. 603(p) of the Fair Credit Reporting Act, 15
30 U.S.C. s. 1681a(p).
31 (2) "Credit score" has the same meaning as provided in s.
32 609(f)(2) of the Fair Credit Reporting Act, 15 U.S.C. s.
33 1681g(f)(2)(A).
34 (3) "Data furnisher" has the same meaning as the term
35 "furnisher" in 12 C.F.R. s. 1022.41(c).
36 (4) "Pilot program" or "program" means the Access to
37 Responsible Credit Pilot Program.
38 (5) "Pilot program license" means a permit issued under
39 ss. 516.40-516.47 to make and collect consumer loans under the
40 pilot program.
41 (6) "Program licensee" means a person who is licensed to
42 make consumer finance installment loans under this chapter and
43 who is approved by the office to participate in the program.

44 (7) "Program loan" means a consumer finance installment
45 loan with a principal amount of at least $300 and no more than
46 $3,000.
47 (8) "Referral partner" means a person who markets program
48 loans and administers and processes program loan applications on
49 behalf of a program licensee at the referral partner's physical
50 business location.
51 (a) The term does not include a person whose sole means of
52 bringing a program licensee and a prospective borrower together
53 at that person's physical business location is an electronic
54 access point through which a prospective borrower may directly
55 access the website of a program licensee.
56 (b) A referral partner is not a credit service
57 organization that term is defined in s. 817.7001 or a loan
58 broker as defined in s. 687.141.
59 (9) "Refinance program loan" means a program loan that
60 replaces and revises an existing program loan contract with a
61 borrower and which results in an extension of additional
62 principal to that borrower.
63 Section 3. Section 516.42, Florida Statutes, is created to
64 read:
65 516.42 Approval required; program application
66 requirements; fees.—
67 (1) A program licensee may not offer or make a program
68 loan, impose any charges or fees pursuant to s. 516.44, or use a

69 referral partner pursuant to s. 516.45, without prior approval
70 from the office to participate in the program.
71 (2) In order to participate in the program, a program
72 licensee must be licensed to make consumer finance installment
73 loans under this chapter, be in good standing with the office,
74 and not be the subject of an outstanding enforcement action or
75 have a deficiency at the time of the person's application. The
76 applicant must file with the office a digital application in a
77 form and manner prescribed by rule of the commission and pay a
78 fee to the office in an amount determined by rule of the
79 commission. In determining the fee, the commission must consider
80 the officer's costs to administer the program.
81 (3) Except as otherwise provided in ss. 516.40-516.47 or
82 by rule of the commission, a program licensee is subject to all
83 the laws and regulations governing consumer finance installment
84 loans under this chapter.
85 (4) A program licensee who desires to participate in the
86 program but who is not licensed to make consumer finance
87 installment loans pursuant to this chapter shall submit a
88 combined application to the office, in a form and manner
89 prescribed by rule of the commission, for licensure under this
90 chapter to make consumer finance installment loans and for
91 admission to the program. The applicant shall pay a fee to the
92 office in an amount equal to the fees that would have been
93 imposed if the applicant had submitted separate applications. To
94 be eligible to apply in this manner, a person must not be the

95 subject of an outstanding enforcement or other disciplinary
96 action by any financial regulatory agency in this state.
97 (5) Notwithstanding s. 516.05(3), the office may grant a
98 person a pilot program license that covers more than one
99 physical business location if the person only offers program
100 loans to prospective borrowers through referral partners
101 approved by the office in accordance with s. 516.45.
102 Section 4. Section 516.43, Florida Statutes, is created to
103 read:
104 516.43 Annual report.—By March 15 of each year, a program
105 licensee shall file a report with the office containing
106 aggregated data, without reference to any borrower's nonpublic
107 personal information or any proprietary or trade secret
108 information of the program licensee, on each of the items
109 specified in s. 516.47 in a manner prescribed by rule of the
110 commission. The report is in addition to any other annual report
111 the program licensee may be required to file.
112 Section 5. Section 516.44, Florida Statutes, is created to
113 read:
114 516.44 Requirements for program loans.—
115 (1) GENERAL REQUIREMENTS.—A program licensee must comply
116 with each of the following requirements in making program loans:
117 (a) A program loan must be unsecured.
118 (b) A program loan must have a minimum term of 120 days,
119 except it may not have a prepayment penalty.

120 (c) A program loan must include a borrower's right to
121 rescind the program loan by notifying the program licensee of
122 the borrower's intent to rescind the program loan and return the
123 principal advanced by the end of the business day after the day
124 the program loan is consummated.
125 (d) Notwithstanding s. 516.031, the interest rate charged
126 on a program loan to the borrower may not exceed 36 percent. The
127 interest rate must be fixed for the life of the program loan and
128 must accrue on a simple-interest basis through the application
129 of a daily periodic rate to the actual unpaid principal balance
130 each day.
131 (e) For a refinance program loan, the principal amount
132 payable may not include more than 60 days' unpaid interest
133 accrued on the previous program loan in accordance with s.
134 516.031(5). A program licensee may not refinance a program loan
135 made under this section unless the borrower is current on his or
136 her outstanding program loan at the time the borrower submits an
137 application to refinance.
138 (f) A program licensee must provide a receipt for payments
139 made in accordance with s. 687.08.
140 (g) A program licensee must comply with the other
141 provisions of this section.
142 (2) WRITTEN DISCLOSURES.—
143 (a) Notwithstanding s. 516.15(1), the loan contract and
144 all written disclosures and statements may be provided in
145 English or another language in which the loan is negotiated.

146 (b) A program licensee must provide those disclosures
147 required by all licensees in s. 516.15 and the following
148 disclosures in clear and distinct terms to the borrower at the
149 time of application:
150 1. The payment amount of each monthly installment.
151 2. The delinquency charge amount.
152 3. The following statement: "Repaying your loan early will
153 lower your borrowing costs by reducing the amount of interest
154 you will pay. This loan has no prepayment penalty."
155 4. A statement describing the borrower's right of
156 rescission as provided in paragraph (1)(c).
157 (c) The written disclosures required in subparagraphs
158 (b)1.-4. must be in a typeface of at least 12-point type. A
159 program licensee may provide the disclosures in a mobile or
160 other electronic application on which the size of the typeface
161 of the disclosure can be manually modified by a prospective
162 borrower, if the prospective borrower is given the option to
163 print the disclosure in a typeface of at least 12-point size or
164 is provided a printed copy of the disclosure by the program
165 licensee with a typeface of at least 12-point size before the
166 program loan is consummated.
167 (3) ORIGINATION FEES.—
168 (a) Notwithstanding s. 516.031, a program licensee may
169 contract for and receive an origination fee from a borrower on a
170 program loan. The origination fee is fully earned immediately

171 upon making the program loan in an amount not to exceed the
172 following:
173 1. Seven percent of the principal amount exclusive of the
174 origination fee or $90, whichever is less, on the first program
175 loan made to a borrower.
176 2. Six percent of the principal amount exclusive of the
177 origination fee or $75, whichever is less, on the second and
178 subsequent program loans made to that borrower.
179 (b) A program licensee may not charge the same borrower an
180 origination fee more than once in any 4-month period.
181 (c) Notwithstanding paragraph (1)(e), a program licensee
182 may not contract for or charge an origination fee in connection
183 with a refinance program loan unless at least 8 months have
184 elapsed since the receipt of a previous origination fee paid by
185 the borrower. For a program loan that is not a refinance program
186 loan, only one origination fee may be contracted for or received
187 until the program loan has been repaid in full.
188 (4) INSUFFICIENT FUNDS FEES AND DELINQUENCY CHARGES.—
189 Notwithstanding s. 516.031, a program licensee approved by the
190 office to participate in the program may:
191 (a) Require payment from a borrower of no more than $25
192 for fees incurred by the program licensee from a dishonored
193 payment due to insufficient funds of the borrower.
194 (b) Nothwitstanding s. 516.031(3)(a)9., contract for and
195 receive a delinquency charge of no more than $14 for each
196 payment in default for at least 7 days if the charge is agreed

197 upon in writing between the parties before imposing the charge.
198 A delinquency fee imposed by a program licensee is subject to
199 all of the following:
200 1. No more than one delinquency fee may be imposed per
201 delinquent payment.
202 2. No more than two delinquency fees may be imposed during
203 a period of 30 consecutive days.
204 3. The program licensee may not sell or assign an unpaid
205 debt to an independent third party for collection unless the
206 debt has been delinquent for at least 30 days.
207 (5) CREDIT EDUCATION.—Before disbursement of program loan
208 proceeds to the borrower, the program licensee must:
209 (a) Direct the borrower to the consumer credit counseling
210 services promoted by the office in accordance with s. 516.32;
211 (b) Invite the borrower to a credit education program or
212 seminar offered by an independent third party; or
213 (c) Provide a credit education program or materials as
214 approved by the office. The borrower may not be required to
215 participate in either of these education programs or seminars. A
216 credit education program or seminar offered pursuant to this
217 subsection must be provided at no cost to the borrower.
218 (6) CREDIT REPORTING.—
219 (a) The program licensee must report each borrower's
220 payment performance to at least one consumer reporting agency
221 that compiles and maintains files on consumers on a nationwide
222 basis upon acceptance as a data furnisher by that consumer

223 reporting agency. For purposes of this section, the term
224 "consumer reporting agency that compiles and maintains files on
225 consumers on a nationwide basis" has the same meaning as in s.
226 603(p) of the Fair Credit Reporting Act, 15 U.S.C. s. 1681a(p).
227 A program licensee that is accepted as a data furnisher after
228 admittance into the program must report the payment performance
229 of all its borrowers since its inception of lending under the
230 program as soon as practicable, but no more than 6 months after
231 its acceptance into the program.
232 (b)1. The office may approve a licensee for the program
233 before the licensee has been accepted as a data furnisher by a
234 consumer reporting agency if the office has a reasonable
235 expectation based on information supplied by the licensee that:
236 a. The licensee will be accepted as a data furnisher once
237 it achieves a lending volume required of data furnishers of its
238 type by a consumer reporting agency; and
239 b. The required lending volume will be achieved within the
240 first 6 months after the licensee commences lending.
241 2. The office shall withdraw approval for pilot program
242 participation from a program licensee that fails to become
243 accepted as a data furnisher by a consumer reporting agency
244 within 6 months after commencing lending under the pilot
245 program.
246 (c) The program licensee must provide each borrower with
247 the name or names of the consumer reporting agency or agencies
248 to which it will report the borrower's payment history. A

249 program licensee that is accepted as a data furnisher after
250 admittance into the program must provide its borrowers as soon
251 as practicable following acceptance as a data furnisher with the
252 name or names of the consumer reporting agency or agencies to
253 which it will report those borrowers' payment histories.
254 (7) PROGRAM LOAN UNDERWRITING.—
255 (a) The program licensee shall underwrite each program
256 loan to determine a borrower's ability and willingness to repay
257 the program loan pursuant to its terms. The program licensee may
258 not make a program loan if it determines that the borrower's
259 total monthly debt service payments at the time of origination,
260 including the program loan for which the borrower is being
261 considered and all outstanding forms of credit that can be
262 independently verified by the program licensee, exceed 50
263 percent of the borrower's gross monthly income.
264 (b)1. The program licensee shall seek information and
265 documentation pertaining to all of a borrower's outstanding debt
266 obligations during the loan application and underwriting
267 process, including loans that are self-reported by the borrower
268 but not available through independent verification. The program
269 licensee shall verify that information using a credit report
270 from at least one consumer reporting agency that compiles and
271 maintains files on consumers on a nationwide basis or through
272 other available electronic debt verification services that
273 provide reliable evidence of a borrower's outstanding debt
274 obligations.

275 2. The program licensee is not required to consider a
276 borrower's loans from friends or family for purposes of
277 determining the borrower's debt-to-income ratio.
278 (c) The program licensee shall also verify the borrower's
279 income to determine the debt-to-income ratio using information
280 from either:
281 1. Electronic means or services that provide reliable
282 evidence of the borrower's actual income; or
283 2. Internal Revenue Service Form W-2, tax returns, payroll
284 receipts, bank statements, or other third-party documents that
285 provide reasonably reliable evidence of the borrower's actual
286 income.
287 (8) PROVISIONS ON WAIVERS.—
288 (a) A program licensee may not require, as a condition of
289 providing the program loan, that the borrower:
290 1. Waive any right, penalty, remedy, forum, or procedure
291 provided for in any law applicable to the program loan,
292 including the right to file and pursue a civil action or file a
293 complaint with or otherwise communicate with the office, any
294 court, or other governmental entity.
295 2. Agree to the application of laws other than those of
296 this state.
297 3. Agree to resolve disputes in a jurisdiction outside of
298 this state.
299 (b) A waiver by a borrower, other than one prohibited
300 under paragraph (a), must be knowing, voluntary, in writing, and

301 not expressly made a condition of doing business with the
302 program licensee. A waiver that is required as a condition of
303 doing business with the program licensee is presumed
304 involuntary, unconscionable, against public policy, and
305 unenforceable. The program licensee has the burden of proving
306 that a waiver of any rights, penalties, forums, or procedures
307 was knowing, voluntary, and not expressly made a condition of
308 the contract with the borrower.
309 (c) A program licensee may not refuse to do business with
310 or discriminate against a borrower or applicant on the basis
311 that the borrower or applicant refuses to waive any right,
312 penalty, remedy, forum, or procedure, including the right to
313 file and pursue a civil action or complaint with, or otherwise
314 notify, the office, a court, or any other governmental entity.
315 The exercise of a person's right to refuse to waive any right,
316 penalty, remedy, forum, or procedure, including a rejection of a
317 contract requiring a waiver, does not affect any otherwise legal
318 terms of a contract or an agreement.
319 (d) This subsection does not apply to any agreement to
320 waive any right, penalty, remedy, forum, or procedure, including
321 any agreement to arbitrate a claim or dispute, after a claim or
322 dispute has arisen. This subsection does not affect the
323 enforceability or validity of any other provision of the
324 contract.
325 Section 6. Section 516.45, Florida Statutes, is created to
326 read:

327 516.45 Referral partners.—

328 (1) REFERRAL PARTNER AGREEMENT.—All arrangements between a
329 program licensee and a referral partner must be specified in a
330 written referral partner agreement between the parties. The
331 agreement must contain a provision that the referral partner
332 agrees to comply with this section and all rules adopted under
333 this section regarding the activities of referral partners, and
334 that the office has access to the referral partner's books and
335 records pertaining to the referral partner's operations under
336 the agreement with the program licensee in accordance with s.
337 516.46(4).

338 (2) PERMITTED SERVICES.—A program licensee may use the
339 services of one or more referral partners as provided in this
340 section. A referral partner may perform one or more of the
341 following services for a program licensee at the referral
342 partner's physical business location:

343 (a) Distributing, circulating, using, or publishing
344 printed brochures, flyers, fact sheets, or other written
345 materials relating to program loans that the program licensee
346 may make or negotiate. The written materials must be reviewed
347 and approved in writing by the program licensee before being
348 distributed, circulated, or published.

349 (b) Providing written factual information about program
350 loan terms, conditions, or qualification requirements to a
351 prospective borrower which have either been prepared by the
352 program licensee or reviewed and approved in writing by the

353 program licensee. A referral partner may discuss the information
354 with a prospective borrower in general terms.
355 (c) Notifying a prospective borrower of the information
356 needed in order to complete a program loan application.
357 (d) Entering information provided by the prospective
358 borrower on a preprinted or electronic application form or in a
359 preformatted computer database.
360 (e) Assembling credit applications and other materials
361 obtained in the course of a credit application transaction for
362 submission to the program licensee.
363 (f) Contacting the program licensee to determine the
364 status of a program loan application.
365 (g) Communicating a response that is returned by the
366 program licensee's automated underwriting system to a borrower
367 or a prospective borrower.
368 (h) Obtaining a borrower's signature on documents prepared
369 by the program licensee and delivering final copies of the
370 documents to the borrower.
371 (i) Disbursing program loan proceeds to a borrower if this
372 method of disbursement is acceptable to the borrower, subject to
373 the requirements of subsection (3). A loan disbursement made by
374 a referral partner under this paragraph is deemed to be made by
375 the program licensee on the date the funds are disbursed or
376 otherwise made available by the referral partner to the
377 borrower.

378 (j) Receiving a program loan payment from the borrower if
379 this method of payment is acceptable to the borrower, subject to
380 the requirements of subsection (3).
381 (3) RECEIPT OR DISBURSEMENT OF PROGRAM LOAN PAYMENTS.—
382 (a) A loan payment made by a borrower to a referral
383 partner under paragraph (2)(j) must be applied to the borrower's
384 program loan and deemed received by the program licensee as of
385 the date the payment is received by the referral partner.
386 (b) A referral partner that receives loan payments must
387 deliver or cause to be delivered to the borrower, at the time
388 that the payment is made by the borrower, a plain and complete
389 receipt showing all of the following:
390 1. The name of the referral partner.
391 2. The total payment amount received.
392 3. The date of payment.
393 4. The program loan balance before and after application
394 of the payment.
395 5. The amount of the payment that was applied to
396 principal, interest, and fees.
397 6. The type of payment made by the borrower.
398 7. The following statement, prominently displayed in a
399 type size equal to or greater than the type size used to display
400 the other items on the receipt: "If you have any questions about
401 your loan now or in the future, you should direct those
402 questions to ...(name of program licensee)... by ...(at least

403 two different ways in which a borrower may contact the program
404 licensee)...."
405 (c) A borrower who submits a loan payment to a referral
406 partner under this subsection is not liable for a failure or
407 delay by the referral partner in transmitting the payment to the
408 program licensee.
409 (d) A referral partner that disburses or receives loan
410 payments pursuant to paragraph (2)(i) or paragraph (2)(j) must
411 maintain records of all disbursements made and loan payments
412 received for a period of at least 2 years, or for 1 month
413 following the completion of a regular examination by the office
414 under s. 516.46, whichever is later.
415 (4) PROHIBITED ACTIVITIES.—A referral partner may not
416 engage in any of the following activities:
417 (a) Providing counseling or advice to a borrower or
418 prospective borrower with respect to any loan term.
419 (b) Providing loan-related marketing material that has not
420 previously been approved by the program licensee to a borrower
421 or a prospective borrower.
422 (c) Negotiating a loan term between a program licensee and
423 a prospective borrower.
424 (d) Offering information pertaining to a single
425 prospective borrower to more than one program licensee, except
426 if a program licensee has declined to offer a program loan to a
427 prospective borrower and has so notified that prospective
428 borrower in writing, the referral partner may then offer

429 information pertaining to a single prospective borrower to
430 another program licensee with whom it has a referral partner
431 agreement.
432 (5) DISCLOSURE NOTICE AND COMMUNICATION.—
433 (a) At the time the referral partner receives or processes
434 an application for a program loan, the referral partner must
435 provide the following statement to the applicant on behalf of
436 the program licensee, in no smaller than 10-point type, and must
437 request that the applicant acknowledge receipt of the statement
438 in writing:
439
440 Your loan application has been referred to us by ...(name of
441 referral partner).... We may pay a fee to ...(name of referral
442 partner)... for the successful referral of your loan
443 application. If you are approved for the loan, ...(name of
444 program licensee)... will become your lender. If you have any
445 questions about your loan, now or in the future, you should
446 direct those questions to ...(name of program licensee)... by
447 ...(insert at least two different ways in which a borrower may
448 contact the program licensee).... If you wish to report a
449 complaint about ...(name of referral partner)... or ...(name of
450 program licensee)... regarding this loan transaction, you may
451 contact the Division of Consumer Finance of the Office of
452 Financial Regulation at ...(telephone number)....
453

454 (b) If the loan applicant has questions about the program
455 loan which the referral partner is not permitted to answer, the
456 referral partner must make a good faith effort to assist the
457 applicant in making direct contact with the program licensee
458 before the program loan is consummated.
459 (c) If the program loan is consummated, the program
460 licensee must provide to the borrower a written copy of the
461 disclosure notice within 2 weeks after the date of the program
462 loan consummation. A program licensee may include the disclosure
463 in its loan contract or as a separate document to the borrower
464 via any means acceptable to the borrower.
465 (6) COMPENSATION.—
466 (a) The program licensee may compensate a referral partner
467 in accordance with a written agreement and a compensation
468 schedule that is mutually agreed to by the program licensee and
469 the referral partner, subject to the requirements in paragraph
470 (b).
471 (b) The compensation of a referral partner by a program
472 licensee is subject to all of the following requirements:
473 1. Compensation may not be paid to a referral partner in
474 connection with a loan application unless that program loan is
475 consummated.
476 2. Compensation may not be paid to a referral partner
477 based upon the principal amount of the program loan.

478 3. Compensation may not be directly or indirectly passed
479 on to a borrower through a fee or other compensation, or a
480 portion of a fee or other compensation charged to a borrower.
481 4. Subject to the limitations specified in subparagraphs
482 1., 2., and 3., the total compensation paid by a program
483 licensee to a referral partner for the services specified in
484 subsection (2) may not exceed the sum of:
485 a. Sixty dollars per program loan, on average, assessed
486 annually whether paid at the time of consummation, through
487 installments, or in a manner otherwise agreed upon by the
488 program licensee and the referral partner; and
489 b. Two dollars per payment received by the referral
490 partner on behalf of the program licensee for the duration of
491 the program loan, if the referral partner receives borrower loan
492 payments on the program licensee's behalf in accordance with s.
493 516.45(3).
494 5. The referral partner's location for services and other
495 information required by subsection (7) must be reported to the
496 office, and the referral partner may not be barred from
497 providing services at that location by the office.
498 (c) Neither the program licensee nor any referral partner
499 may pass on to a borrower, whether directly or indirectly, any
500 additional cost or other charge for compensation paid to a
501 referral partner under this program.
502 (7) NOTICE TO OFFICE.—A program licensee that uses the
503 service of a referral partner must notify the office within 15

504 days after entering into a contract with a referral partner, on
505 a form prescribed by rule of the commission, regarding all of
506 the following:
507 (a) The name, business address, and licensing details of
508 the referral partner and all locations at which the referral
509 partner will perform services under this section.
510 (b) The name and contact information for an employee of
511 the referral partner who is knowledgeable about, and has the
512 authority to execute, the referral partner agreement.
513 (c) The name and contact information of one or more
514 employees of the referral partner who are responsible for that
515 referral partner's referring activities on behalf of the program
516 licensee.
517 (d) Any other information requested by the office, subject
518 to the limitations specified in s. 516.46(4).
519 (8) APPROVAL OF REFERRAL PARTNERS.—A program licensee's
520 application to use a referral partner must be submitted to the
521 office electronically on a form approved by the office. The
522 office shall approve or deny the application within 30 days
523 after the office receives the completed application and payment
524 of the applicable fee. Unless the office denies the application
525 within the 30-day period, the application is deemed approved by
526 the office.
527 Section 7. Section 516.46, Florida Statutes, is created to
528 read:
529 516.46 Examinations and grounds for disciplinary action.—

530 (1) Notwithstanding any other law, the office must examine
531 each program licensee that is accepted into the program in
532 accordance with this chapter, provided that such examination
533 occurs at least once every 24 months.
534 (2) Notwithstanding subsection (1), the office may waive
535 one or more branch office examinations if the office deems that
536 such examinations are not necessary for the protection of the
537 public due to the centralized operations of the program licensee
538 or other factors acceptable to the office.
539 (3) The examined program licensee must pay for the cost of
540 an examination to the office and the office may maintain an
541 action for the recovery of the cost in any court of competent
542 jurisdiction. In determining the cost of the examination, the
543 office may use the estimated average hourly cost for all persons
544 performing examinations of program licensees or other persons
545 subject to ss. 516.40-516.47 for the fiscal year.
546 (4) The scope of any investigation or examination of a
547 program licensee or referral partner shall be limited to those
548 books, accounts, records, documents, materials, and matters
549 necessary to determine compliance with this chapter.
550 Notwithstanding ss. 516.11 and 516.12, a program licensee may
551 provide information or materials demonstrating compliance with
552 this chapter in an aggregated or anonymized format that excludes
553 proprietary and trade secret information, and may redact
554 proprietary and trade secret information in its books, accounts,
555 records, documents, materials, and matters.

556 (5) A program licensee or referral partner who violates
557 any applicable provision of this chapter is subject to
558 disciplinary action pursuant to s. 516.07(2). A program licensee
559 is also subject to disciplinary action for a violation of s.
560 516.45 committed by any of its referral partners.
561 Section 8. Section 516.47, Florida Statutes, is created to
562 read:
563 516.47 Report by the office.—
564 (1) By January 1, 2018, the office must post a report on
565 its website summarizing the use of the program.
566 (2) The report must state the information in aggregate so
567 as not to identify data by specific program licensee.
568 (3) The office's report must specify the period to which
569 the report corresponds and must include, but not be limited to,
570 the following for that period:
571 (a) The number of entities that applied to participate in
572 the program.
573 (b) The number of entities accepted to participate in the
574 program.
575 (c) The reasons for rejecting applications for
576 participation, if applicable. This information must be provided
577 in a manner that does not identify the entity or entities
578 rejected.
579 (d) The number of program loan applications received by
580 program licensees participating in the program, the number of
581 program loans made pursuant to the program, the total amount

582 loaned, the distribution of loan lengths upon origination, and
583 the distribution of interest rates and principal amounts upon
584 origination among those program loans.
585 (e) The number of borrowers who obtained more than one
586 program loan and the distribution of the number of program loans
587 per borrower.
588 (f) Of the borrowers who obtained more than one program
589 loan, the percentage of those borrowers whose credit scores
590 increased between successive loans, based on information from at
591 least one major credit bureau, and the average size of the
592 increase.
593 (g) The income distribution of borrowers upon program loan
594 origination, including the number of borrowers who obtained at
595 least one program loan and who resided in a low-income or
596 moderate-income census tract at the time of their loan
597 applications.
598 (h) The number of borrowers who obtained program loans for
599 the following purposes, based on borrower responses at the time
600 of their loan applications, indicating the primary purpose for
601 which the program loan was obtained:
602 1. Pay medical expenses.
603 2. Pay for vehicle repair or a vehicle purchase.
604 3. Pay bills.
605 4. Consolidate debt.
606 5. Build or repair credit history.
607 6. Pay other expenses.

608 (i) The number of borrowers who self-report that they had
609 a bank account at the time of their loan application and the
610 number of borrowers who self-report that they did not have a
611 bank account at the time of their loan application.
612 (j) With respect to refinance program loans, the report
613 must specifically include the following information:
614 1. The number and percentage of borrowers who applied for
615 a refinance program loan.
616 2. Of those borrowers who applied for a refinance program
617 loan, the number and percentage of borrowers who obtained a
618 refinance program loan.
619 (k) The number and type of referral partners used by
620 program licensees.
621 (l) The number and percentage of borrowers who obtained
622 one or more program loans on which delinquency charges were
623 assessed, the total amount of delinquency charges assessed, and
624 the average delinquency charge assessed by dollar amount and as
625 a percentage of the principal amount loaned.
626 (m)1. The performance of program loans under the program
627 as reflected by all of the following:
628 a. The number and percentage of borrowers who experienced
629 at least one delinquency lasting between 7 and 29 days and the
630 distribution of principal loan amounts corresponding to those
631 delinquencies.
632 b. The number and percentage of borrowers who experienced
633 at least one delinquency lasting between 30 and 59 days and the

634 distribution of principal loan amounts corresponding to those
635 delinquencies.
636 c. The number and percentage of borrowers who experienced
637 at least one delinquency lasting 60 days or more and the
638 distribution of principal loan amounts corresponding to those
639 delinquencies.
640 2. To the extent data are readily available to the office,
641 the office shall include in its report comparable delinquency
642 data for unsecured loans made by licensed persons under ss.
643 516.001-516.36 and part IV of chapter 560 for principal loan
644 amounts between $300 and $3,000, and for unsecured extensions of
645 credit made by state-chartered banks and credit unions under the
646 office's jurisdiction in principal loan amounts between $300 and
647 $3,000.
648 (n) The number and types of violations of ss. 516.40-
649 516.47 by referral partners which were documented by the office.
650 (o) The number and types of violations of ss. 516.40-
651 516.47 by program licensees which were documented by the office.
652 (p) The number of times that the office disqualified a
653 referral partner from performing services, barred a referral
654 partner from performing services at one or more specific
655 locations of the referral partner, terminated a written
656 agreement between a referral partner and a program licensee, or
657 imposed an administrative penalty.

658 (q) The number of complaints received by the office about
659 a program licensee or a referral partner and the nature of those
660 complaints.
661 (r) Recommendations for improving the program.
662 (s) Recommendations regarding whether the program should
663 be continued after January 1, 2022.
664 (4) The office shall conduct a random sample survey of
665 borrowers who have participated in the program to obtain
666 information regarding the borrowers' experience and program
667 licensees' compliance with ss. 516.40-516.47. The results of
668 this survey shall be included in the report required by this
669 section.
670 Section 9. Sections 516.40, 516.41, 516.42, 513.43,
671 516.44, 516.45, 516.46, and 516.47, Florida Statutes, are
672 repealed January 1, 2022.
673 Section 10. This act shall take effect January 1, 2017.
674
675 ----------
676 **T I T L E A M E N D M E N T**
677 Remove everything before the enacting clause and insert:
678 A bill to be entitled
679 An act relating to consumer finance loans; creating s.
680 516.40, F.S.; establishing the Access to Responsible
681 Credit Pilot Program; providing legislative findings
682 and intent; providing applicability; creating s.
683 516.41, F.S.; defining terms; creating s. 516.42,

684 F.S.; prohibiting a person from certain activities
685 without prior approval from the Office of Financial
686 Regulation; specifying requirements for participating
687 in the program to make certain consumer finance
688 installment loans; specifying requirements for an
689 application and fee; authorizing the office to grant a
690 person a license covering more than one physical
691 location under certain circumstances; creating s.
692 516.43, F.S.; requiring a program licensee to file
693 annual reports; creating s. 516.44, F.S.; providing
694 general requirements for a program loan; requiring a
695 program licensee to provide specified written
696 disclosures to a borrower; specifying requirements for
697 origination fees; specifying requirements for
698 insufficient funds fees and delinquency charges;
699 requiring a program licensee to offer certain credit
700 education to a borrower; specifying requirements for
701 reporting borrower payment performance to credit
702 reporting agencies; authorizing the office to approve
703 a licensee for the program before it has been accepted
704 as a data furnisher under certain circumstances;
705 requiring a program licensee to provide certain
706 information relating to credit reporting agencies;
707 specifying requirements for a program licensee to
708 underwrite program loans; prohibiting a program
709 licensee from requiring certain waivers from a

710 borrower; specifying requirements for permissible
711 waivers; prohibiting certain actions by a program
712 licensee; providing applicability; creating s. 516.45,
713 F.S.; requiring a program licensee and a referral
714 partner to enter into a written referral partner
715 agreement; specifying permitted services by a referral
716 partner; specifying procedures for receipt or
717 disbursement by a referral partner of program loan
718 payments made by a borrower; providing that a borrower
719 who submits a loan payment to a referral partner is
720 not liable under certain circumstances; requiring a
721 referral partner to maintain certain records;
722 prohibiting certain activities by a referral partner;
723 specifying disclosure notice requirements; specifying
724 requirements and prohibitions for compensation from a
725 program licensee to a referral partner; requiring a
726 program licensee to provide the office with a
727 specified notice after contracting with a referral
728 partner; requiring the office to approve or deny an
729 application within 30 days; creating s. 516.46, F.S.;
730 requiring the office to examine program licensees at
731 specified intervals; providing an exception; requiring
732 program licensees to pay the cost of examinations;
733 authorizing the office to maintain an action of
734 recovery of the cost; authorizing a manner to
735 determine the cost of examinations; providing

736 limitations of an investigation; providing for
737 disciplinary action; creating s. 516.47, F.S.;
738 requiring the office to post a report to its website
739 summarizing the use of the program by a certain date;
740 specifying information to be contained in the report;
741 requiring the office to conduct a specified survey of
742 borrowers and include the results in the report;
743 providing for the future repeal of ss. 516.40, 516.41,
744 516.42, 513.43, 516.44, 516.45, 516.46, and 516.47,
745 F.S., relating to the Access to Responsible Credit
746 Pilot Program; providing an effective date.

PCS for HB 583

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 583 Provision of Pharmaceutical Services
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** SB 780

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Peterson KP	Luczynski MJ

SUMMARY ANALYSIS

The federal Patient Protection and Affordable Care Act (PPACA) imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.

PPACA requires qualified health plans to provide coverage of essential health benefits (EHB), meet cost-sharing limits, and meet actuarial value requirements. The law directs that EHBs cover at least 10 specified categories, which includes prescription drugs. Currently, the EHB requirements apply only to plans offered in the individual or small group market (less than 50 employees). Plans offered in the large group market are not covered.

The federal Department of Health and Human Services has updated the notice of benefit and payment parameters, which establish key standards for issuers and marketplaces. These regulations include provisions relating to prescription drug coverage, formulary drug lists, the drug exception process, and access to retail pharmacies. For plan years beginning January 1, 2017, the final regulation requires health plans sold in the individual and small group markets to allow enrollees to obtain most drugs at network retail pharmacies as an alternative to mail order. Exceptions to the requirement include drugs that are subject to restricted distribution by the U.S. Food and Drug Administration, or drugs that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. A plan may charge a different cost-sharing amount for drugs that are obtained at a network retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing.

The PCS requires insurers and health maintenance organizations that provide coverage for prescription drugs to allow patients with a diagnosis of human immunodeficiency virus to access pharmaceutical services at retail pharmacies. Qualified retail pharmacies include network pharmacies and out-of-network pharmacies that the insurer or HMO credentials for the limited purpose of providing pharmaceutical services to these patients. The PCS allows an insurer or HMO to charge a fee for credentialing of up to $1,500.

An insurer or HMO may charge a higher copayment or coinsurance to patients who access services at a retail pharmacy, but must charge the same copayment or coinsurance amounts whether the patient uses a network retail pharmacy or an out-of-network pharmacy that has been credentialed for this limited purpose. All cost-sharing is credited against the annual limit imposed by PPACA. Reimbursement to a network retail pharmacy is as set forth in the contract between the pharmacy and the insurer or HMO. Reimbursement to an out-of-network pharmacy that is providing pharmaceutical services pursuant to the PCS is at the mail order rate.

The bill does not appear to have a fiscal impact on local government, but will have an indeterminate negative fiscal impact on the State Group Health Insurance Program.

The PCS provides an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Patient Protection and Affordable Care Act

The federal Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.[1] PPACA imposes many insurance requirements including required benefits, rating and underwriting standards, required review of rate increases, reporting of medical loss ratios and payment of rebates, coverage for adult dependents, internal and external appeals of adverse benefit determinations, and other requirements.[2]

Qualifying coverage may be obtained through an employer, the federal or state marketplaces or exchanges created under PPACA, or private individual or group coverage meeting the minimum essential benefits coverage standard off the exchange. 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. Premium credits are set on a sliding scale based on a percentage of the federal poverty level and reduce the out-of-pocket costs incurred by individuals and families.

Prior to an insurer offering a plan through an exchange, an exchange must certify that the plan meets certain federal essential health benefits and other requirements to be deemed a qualified health plan. Section 1302 of the Affordable Care Act requires qualified health plans to provide coverage of essential health benefits (EHB), meet cost-sharing limits, and meet actuarial value requirements. The law directs that EHBs cover at least 10 specified categories, which include prescription drugs. Currently, the EHB requirements apply only to plans offered in the individual or small group market (less than 50 employees). Plans offered in the large group market are not covered.

Final Notice of Benefit and Payment Parameters for 2016[3]

On February 27, 2015, the federal Department of Health and Human Services (HHS) published its final regulations relating to notice of benefit and payment parameters, which establishes key standards for individual and small group issuers and marketplaces for 2016. These regulations include provisions relating to prescription drug coverage, formulary drug lists, the drug exception process, and access to retail pharmacies.

Prescription Drug Coverage

Currently, for purposes of complying with the EHBs, insurers and HMOs must include in their formulary drug list the greater of one drug for each U.S. Pharmacopeia (USP) category and class; or the same number of drugs in each USP category and class as the state's essential health benefit (EHB) benchmark plan.[4,5] For plan years beginning on or after January 1, 2017, plans must also use a pharmacy and therapeutic committee system that will design formularies using scientific evidence that

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[1] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148. On March 30, 2010, PPACA was amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.
[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] Dept. of Health and Human Services, *Final HHS Notice of Benefit and Payment Parameters for 2016, available at* http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2016-PN-Fact-Sheet-final.pdf (last visited Jan. 29, 2016).
[4] Florida's benchmark plan is published on the CMS website. *See* CMS.GOV, THE CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, *INFORMATION ON ESSENTIAL HEALTH BENEFITS (EHB) BENCHMARK PLANS,* https://www.cms.gov/cciio/resources/data-resources/ehb.html (last visited Jan.29, 2016).
[5] 45 CFR §. 156.122(a).

will include consideration of safety and efficacy, cover a range of drugs in a broad distribution of therapeutic categories and classes, and provide access to drugs that are included in broadly accepted treatment guidelines.[6]

Formulary Drug List.

The regulations require a health plan to publish an up-to-date and complete list of all covered drugs on its formulary drug list, including any tiering structure and any restrictions on the manner in which a drug can be obtained. The information must be published in a manner that is easily accessible to plan enrollees, prospective enrollees, the state, the marketplace, the HHS, and the public. Additionally, insurers and HMOs must also make this information available in a standard-readable format to provide the opportunity for third parties to create resources that aggregate information on different plans.

Drug Exceptions Process

Under current HHS regulations, plans providing EHBs must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not included on the plan's formulary drug list. [7] The final regulation clarifies that cost sharing for the non-formulary drug provided through the exceptions process counts towards the annual limitation on cost sharing and actuarial value of the plan.

Drug Mail Order Opt Out

For plan years beginning January 1, 2017, the final regulation requires health plans to allow enrollees to obtain most drugs at network retail pharmacies as an alternative to mail order. Exceptions to the requirement include drugs that are subject to restricted distribution by the U.S. Food and Drug Administration, or drugs that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. A plan may charge a different cost-sharing amount for drugs that are obtained at a network retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing.[8] In effect, the requirement would prohibit a health plan that is required to cover the EHB package from offering a mail-order, only prescription drug benefit.

In its response to comments on this provision of the rule, the HHS stated:[9]

> We also believe that making drugs available only by mail order could discourage enrollment by, and thus discriminate against, transient individuals and individuals who have conditions that they wish to keep confidential.

The HHS also noted that the drugs on the specialty tier of a formulary are not necessarily the same drugs that a specialty pharmacy would provide and that exceptions will be needed for many drugs that are only accessible via a specialty pharmacy. For this reason, the HHS included the two exceptions.[10]

<u>Cost-Sharing Limitations</u>

PPACA requires non-grandfathered health plans to limit the amount that enrollees must pay out-of-pocket for EHBs accessed through a network provider. These limits apply to plans offered in the small group, individual, and large group markets. For 2016, these limits are $6,850 (individual)/$13,700 (family). Effective with the plan year beginning January 1, 2016, plans subject to the cost-sharing

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[6] *Supra* note 3.

[7] 45 C.F.R. § 156.122(c). The drug exception process is distinct from the coverage appeals process, which applies if an enrollee receives an adverse benefit determination for a drug that is included on the plan's formulary drug list. The coverage appeals process has separate requirements for its external review process and allows for a secondary level of internal review before the final internal review determination for group plans. 45 C.F.R. § 147.136.

[8] 45 C.F.R. § 156.122(e).

[9] PPACA, HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10821 ((2015).

[10] *Id.* at 10821.

limitation are required to apply the self-only (individual) limit to each individual member of family.[11] In effect, a single enrollee will not be required to pay more than $6,850 in cost sharing for in-network benefits, even if the enrollee is covered by a plan that has a family out-of-pocket maximum that has not yet been met. Once the limit is reached, the plan must pay 100 percent for covered network benefits.

State Regulation of Insurance

The regulatory oversight of insurance companies is generally reserved to the states. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code.[12]

To operate in Florida, an HMO must obtain a certificate of authority from OIR.[13] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA pursuant to part III of ch. 641, F.S.[14] As part of the certification process used by AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[15]

Human Immunodeficiency Virus

Human immunodeficiency virus (HIV) is an immune system virus that can lead to the fatal acquired immunodeficiency syndrome (AIDS). HIV affects specific cells of the immune system and over time the virus can destroy so many of these cells that the body cannot fight off infections and disease. There is no cure for HIV, yet with proper medical care, HIV can be controlled.[16]

HIV is typically spread by having unprotected sex with someone who has HIV, or sharing needles, syringes, or other equipment used to prepare injection drugs with someone who has HIV. As of the end of 2012, about 1.2 million people in the United States were living with HIV, including 156,300 people whose infections had not been diagnosed. Approximately 50,000 people get infected with HIV each year.[17] In 2014, the estimated number of adults and children living with AIDS in Florida was 110,000. The number of newly-diagnosed cases was 5,897.[18] Florida consistently ranks at or near the top of states for its number of reported cases and new diagnoses annually.

Effect of the PCS

The PCS requires insurers and health maintenance organizations that provide coverage for prescription drugs to allow patients with a diagnosis of HIV to access pharmaceutical services at retail pharmacies. Qualified retail pharmacies include network pharmacies and out-of-network pharmacies that the insurer or HMO credentials for the limited purpose of providing pharmaceutical services to

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[11] U.S. DEPT. OF LABOR, *FAQsabout Affordable Care Act Implementation (Part XXVII),* http://www.dol.gov/ebsa/faqs/faq-aca27.html (last visited Jan. 29, 2016).
[12] s. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet).
[13] ss. 641.21(1) and. 641.49, F.S.
[14] ss. 641.21(1) and 641.48, F.S.
[15] s. 641.495, F.S.
[16] CENTERS FOR DISEASE CONTROL AND PREVENTION, *About HIV/AIDS,* http://www.cdc.gov/hiv/basics/whatishiv.html (last visited Jan. 29, 2016).
[17] CENTERS FOR DISEASE CONTROL AND PREVENTION, HIV/AIDS, *Statistics Overview*, http://www.cdc.gov/hiv/statistics/overview/ (last visited Jan. 29, 2016).
[18] FLORIDA DEPT. OF HEALTH, *State HIV/AIDS Slide Sets, http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/epi-slide-sets.html.*

these patients. The PCS allows an insurer or HMO to charge a fee for credentialing an out-of-network retail pharmacy of up to $1,500.

An insurer or HMO may charge a higher copayment or coinsurance to patients who access services at a retail pharmacy, but must charge the same copayment or coinsurance amounts whether the patient uses a network retail pharmacy or an out-of-network pharmacy that has been credentialed for this limited purpose. All cost sharing is credited against the annual limit imposed by PPACA. Reimbursement to a network retail pharmacy is as set forth in the contract between the pharmacy and the insurer or HMO. Reimbursement to an out-of-network pharmacy that is providing pharmaceutical services pursuant to the PCS is at the mail order rate.

The PCS provides an effective date of July 1, 2016.

B. SECTION DIRECTORY:

Section 1: creates ss. 627.6442, F.S., related to pharmaceutical services.
Section 2: amends s. 641.31, F.S., related to health maintenance contracts.
Section 3: provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The PCS may have a negative fiscal impact on the State Group Health Insurance Program (GHIP). Currently, the GHIP allows members to use any retail pharmacy that accepts the same reimbursement as a mail order pharmacy for up to a 90-day supply of all non-specialty maintenance medications. These retail pharmacies may be participating either in the pharmacy benefit manager's (PBM) retail pharmacy network or the state's specific "maintenance 90 at retail" pharmacy network. Cost sharing for a 90-day supply is the same under the GHIP for drugs accessed at a retail pharmacy or a mail order pharmacy.[19] Reimbursement to retail pharmacies is the same rate as mail order pharmacies under contract with the state.[20] The GHIP complies with these elements of the PCS.

   Where the GHIP differs is with respect to the specialty medications. The state's current contract with the PBM requires the state's specialty medication to be dispensed by the PBM, which is considered mail order. If the state has to renegotiate its contract to allow retail pharmacies to dispense these medications, thereby eliminating the exclusivity provision of the contract, pricing may be negatively affected.[21]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   Not applicable. This bill does not appear to affect county or municipal governments.

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[19] Florida Dept. of Management Services, Agency Analysis of 2016 HB 535, p. 2 (Dec. 16, 2015). The analysis was drafted to the bill, as filed, and not the PCS. However, the discussion above is still relevant to provisions in the PCS.
[20] s. 110.12315(3), F.S.
[21] *Supra* note 19, at p. 3.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health insurers and HMOs will incur administrative costs to implement the requirements of the PCS. Proponents of the filed bill estimate that 20 percent of the people living with HIV are covered by a commercial plan. The remainder are either uninsured or covered by a government-sponsored program. This would mean that the PCS would affect approximately 20,000 covered lives. Thus, the financial impact to the plans likely would be more in the cost to develop the infrastructure to administer the requirement than in the effect on drug pricing.

People living with HIV would benefit from the opportunity to access medications locally and to use manufacturer-offered cards that provide financial assistance with copayment and coinsurance.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable. The adoption of rules is not necessary to implement the provisions of the bill

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the provision of pharmaceutical
3 services; creating s. 627.6442, F.S., relating to
4 health insurers, and amending s. 641.31, F.S.,
5 relating to health maintenance organizations;
6 providing that an insured or subscriber with a
7 diagnosis of human immunodeficiency virus must be
8 allowed to access pharmaceuticals at a network retail
9 pharmacy or a pharmacy credentialed by the insurer for
10 this purpose; proving for a credentialing application
11 fee; providing for cost-sharing by the insured or the
12 subscriber; providing for reimbursement to the health
13 insurer or health maintenance organization; providing
14 an effective date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Section 627.6442, Florida Statutes, is created
19 to read:
20 627.6442 Provision of pharmaceutical services
21 (1) A health insurance policy, health care services plan,
22 or other contract issued, delivered, or renewed by a health
23 insurer in this state that provides coverage for prescription
24 drugs must allow insureds with a diagnosis of human
25 immunodeficiency virus to access pharmaceutical services at
26 network retail pharmacies or at credentialed out-of-network

27 retail pharmacies. Out-of-network retail pharmacies shall be
28 credentialed by the health insurer pursuant to subsection (2)
29 for the limited purpose of providing pharmaceutical services
30 under this section.
31 (2) The health insurer shall credential an out-of-network
32 retail pharmacy that applies to provide pharmaceutical services
33 to insureds with a diagnosis of human immunodeficiency virus
34 according to the same procedures and criteria used by the health
35 insurer to select retail pharmacies for inclusion in the health
36 insurer's network of providers. The health insurer may charge
37 the out-of-network retail pharmacy a reasonable fee to cover the
38 cost of credentialing not to exceed $1,500.
39 (3) A health insurer may charge an insured a cost-sharing
40 amount for obtaining a covered drug at a retail pharmacy that is
41 different from the cost-sharing amount for obtaining a covered
42 drug at a mail order pharmacy, but may not charge an amount for
43 obtaining a covered drug at an out-of-network retail pharmacy
44 that has been credentialed by the health insurer pursuant to
45 subsection (2) which is higher than the amount charged for
46 obtaining a covered drug at a network retail pharmacy. All cost
47 sharing will count towards the plan's annual limitation on
48 network cost sharing as provided in 45 CFR s. 156.130. Any
49 retail pharmacy that provides pharmaceutical services pursuant
50 to this section shall be treated as a network provider for
51 purposes of calculating and applying cost-sharing paid by, or on
52 behalf of, an insured to the plan's annual limits. The cost-

53 sharing limitations shall apply to plans issued, delivered, or
54 renewed in the small group, individual, and large group markets.
55 (4) The reimbursement rate for network retail pharmacies
56 shall be as provided in the contract between the network retail
57 pharmacy and the health insurer. The reimbursement rate for out-
58 of-network retail pharmacies that have been credentialed by the
59 insurer pursuant to subsection (2) shall be at the same rate as
60 mail order pharmacies under contract with the health insurer.
61 Section 2. Subsection (44) is added to section 641.31,
62 Florida Statutes, to read:
63 641.31 Health maintenance contracts. -
64 (44)
65 (a) A health maintenance contract that provides coverage
66 for prescription drugs must allow subscribers with a diagnosis
67 of human immunodeficiency virus to access pharmaceutical
68 services at network retail pharmacies or at credentialed out-of-
69 network retail pharmacies. Out-of-network pharmacies shall be
70 credentialed by the health maintenance organization pursuant to
71 paragraph (b) for the limited purpose of providing
72 pharmaceutical services under this subsection.
73 (b) The health maintenance organization shall credential
74 an out-of-network retail pharmacy that applies to provide
75 pharmaceutical services to subscribers with a diagnosis of human
76 immunodeficiency virus according to the same procedures and
77 criteria used by the health maintenance organization to select
78 retail pharmacies for inclusion in the health maintenance

79 organization's network of providers. The health maintenance
80 organization may charge the out-of-network retail pharmacy a
81 reasonable fee to cover the cost of credentialing not to exceed
82 $1,500.
83 (c) A health maintenance organization may charge a
84 subscriber a cost-sharing amount for obtaining a covered drug at
85 a retail pharmacy that is different from the cost-sharing amount
86 for obtaining a covered drug at a mail order pharmacy, but may
87 not charge an amount for obtaining a covered drug at an out-of-
88 network retail pharmacy that has been credentialed by the health
89 maintenance organization pursuant to paragraph (b) which is
90 higher than the amount charged for obtaining a covered drug at a
91 network retail pharmacy. All cost sharing will count towards the
92 plan's annual limitation on network cost sharing as provided in
93 45 CFR s. 156.130. Any retail pharmacy that provides
94 pharmaceutical services pursuant to this subsection shall be
95 treated as a network provider for purposes of calculating and
96 applying cost-sharing paid by, or on behalf of, a subscriber to
97 the plan's annual limits. The cost-sharing limitations shall
98 apply to plans issued, delivered, or renewed in the small group,
99 individual, and large group markets.
100 (d) The reimbursement rate for network retail pharmacies
101 shall be as provided in the contract between the network retail
102 pharmacy and the health maintenance organization. The
103 reimbursement rate for out-of-network retail pharmacies that
104 have been credentialed by the health maintenance organization

105 pursuant to paragraph (b) shall be at the same rate as mail
106 order pharmacies under contract with the health maintenance
107 organization
108 Section 3. This act shall take effect July 1, 2016.

PCS for HB 713

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 713 Consumer Debt Collection
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 562

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Bauer	Luczynski

SUMMARY ANALYSIS

Consumer debt covers non-business debt such as mortgages, credit cards, medical debts, and other debts mainly for personal, family, or household purposes. If a borrower defaults on a consumer debt, the lender will initiate collection efforts, usually through the sale or assignment of the asset to a third-party debt collector. State and federal debt collection laws provide consumer protection against deceptive, unfair, or abusive collection practices that can occur before the debtor is sued, as well as during the litigation process.

At the state level, the Florida Consumer Collection Practices Act (the Act) regulates consumer collection agencies and prohibits many of the same debt collection practices prohibited by the federal Fair Debt Collection Practices Act. The Act gives primary oversight authority to the Office of Financial Regulation (OFR). Both acts contain civil remedies for debtors, providing that any person who commits a prohibited practice is liable for up to $1,000 in statutory damages and attorney's fees and costs.

Both federal and Florida law prohibit communications with a debtor if the person *knows* that the debtor is represented by an attorney with respect to such debt, and has knowledge of or can readily ascertain such attorney's name and address, subject to certain exceptions. However, while the federal law only applies to third-party debt collectors, Florida law prohibits "any person" from engaging in certain collection practices such as knowingly communicating with represented debtors. As a result, original creditors in Florida have asserted that they have been exposed to litigation after sending invoices to debtors and without receiving clear and adequate notice of the debtor's representation by legal counsel.

The proposed committee substitute (PCS) clarifies how a debtor or his or her attorney may provide notice of representation by legal counsel by:

- Providing that the *debtor*, individually, may notify such person (i.e., the original creditor or debt collector) of the legal representation by way of any reasonable means, including verbal notices.
- Providing that the *debtor's attorney* may notify the original creditor that he or she represents the debtor with respect to such debt through one of three means: service of pleadings in a filed action, written notice by certified mail to the original creditor's registered agent, or other written notification means designated by an original creditor in a bill statement.

Secondly, the PCS prohibits any person from using false representation or deceptive or unfair means to collect or attempt to collect any debt or to obtain information concerning a consumer. Similar prohibitions currently exist in the federal Act.

The PCS has no impact on local governments, and an indeterminate impact on state governments and the private sector. The extent of administrative fines that could be assessed and civil cases initiated as a result of the new prohibited practice is unknown

The PCS has an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Consumer debt covers non-business debt such as mortgages, credit cards, medical debts, and other debts mainly for personal, family, or household purposes. Depending on the terms of the loan, a grace period may be provided before a debt becomes delinquent. Generally, most credit issuers will attempt to collect on a delinquent debt between 120-180 days after delinquency, before it is deemed uncollectible and is "charged off" corporate records.[1] Typically, the charged-off debt is then either assigned or sold as part of a portfolio to a third-party collection agency or collection law firm, which can in turn use a variety of collection methods and judgment remedies to recover the asset, subject to applicable statutes of limitations. These remedies enable creditors to minimize losses due to non-repayment by borrowers, and help ensure the availability and affordability of consumer credit.

Among all consumer debt types, medical debt dominates the list. Nationally, 52 percent of all collection accounts on credit reports are medical, compared to unclassified debt (17.3 percent), cable or cellular debt (8.2 percent), utilities debt (7.3 percent), and retail debt (7.2 percent). An estimated 43 million consumers with a credit report at a nationwide consumer reporting agency have one or more medical accounts in collection.[2] Based on 2013 statistics from U.S. bankruptcy courts, one study estimated medical bankruptcy rates to be 57.1 percent of U.S. bankruptcies. California, Illinois, and Florida account for over a quarter of those living in medical-related bankruptcy.[3]

State and federal debt collection laws provide consumer protections against certain abusive, harassing, and intrusive collection practices that may occur before the debtor is sued, as well as during the litigation process. Both federal and Florida law define "debt collector" as any person who uses any instrumentality of interstate commerce in any business the principal purpose of which is the collection of debts, or who regularly collects or attempts to collect, directly or indirectly, debts owed or due to asserted to be owed or due another.[4] The definition of "debt collector" under both federal and Florida law excludes persons such as original creditors and their in-house collectors and persons serving legal process in connection with the judicial enforcement of any debt.

Since September 2013, debt collection has been the top consumer complaint at the federal Consumer Financial Protection Bureau (CFPB), the primary federal agency which enforces the federal Fair Debt Collection Practices Act.[5] Among the CFPB's data on consumer complaints regarding debt collection, the most common type of debt collection complaint is about continued attempts to collect a debt that the consumer reports is not owed (37 percent), followed by communications tactics, particularly phone calls (20 percent). One of the least common complaints received by the CFPB relates to consumers reporting that they are contacted directly, instead of the debt collector contacting their attorney (2 percent).[6]

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[1] The Uniform Retail Credit Classification and Account Management Policy, set forth by the Federal Financial Institutions Examination Council, established uniform guidelines for issuers of retail credit regarding the charge-off timeframes for open-end and closed-end credit. 65 Fed. Reg. 36,903 (Jun 12, 2000). It should be noted that a "charge-off" does not mean the debtor is discharged from repaying the loan; in fact, a charge-off is reported as an adverse event to credit reporting agencies.

[2] CONSUMER FINANCIAL PROTECTION BUREAU, *Here's how medical debt hurts your credit report*, at http://www.consumerfinance.gov/blog/heres-how-medical-debt-hurts-your-credit-report/ (last visited Jan. 28, 2016).

[3] NerdWallet, *NerdWallet Health Finds Medical Bankruptcy Accounts for Majority of Personal Bankruptcy*, at http://www.nerdwallet.com/blog/health/medical-bankruptcy/ (last visited Jan. 28, 2016).

[4] Section 559.55(6), F.S., and 15 U.S.C. § 1692a(6).

[5] See footnote 2, *supra*.

[6] CONSUMER FINANCIAL PROTECTION BUREAU, *Fair Debt Collection Practices Act Annual Report* (2015) (pp. 12-15), at http://files.consumerfinance.gov/f/201503_cfpb-fair-debt-collection-practices-act.pdf.

Federal Regulation of Debt Collection

In 1977, Congress enacted the Fair Debt Collection Practices Act (the federal Act) to "eliminate abusive debt collection practices...to insure that those debt collectors who refrain from using abusive debt collection practices are not competitively disadvantaged, and to promote consistent State action to protect consumers against debt collection abuses."[7] The Act is primarily enforced by the CFPB, in coordination with the Federal Trade Commission. The federal Act is also enforced by other federal agencies with respect to specific industries subject to other federal laws, such as financial institutions (e.g., banks, savings associations, and credit unions).[8] As a result of the federal Dodd-Frank Wall Street Reform Act of 2010, the CFPB was given rulemaking authority to define and supervise "larger participants" of certain nonbank consumer financial product and service markets, including debt collection. The CFPB test to define these "larger participants" means the covered person's annual receipts resulting from consumer debt collection exceed $10 million.

The federal Act prohibits third-party debt collectors from engaging in certain types of abusive, harassing, unfair, or deceptive conduct in collecting or attempting to collect a debt. However, the federal Act does not apply to original creditors.

State Regulation of Debt Collection

In 1972, Florida enacted the Florida Consumer Collection Practices Act (the Act), codified in part VI of ch. 559, F.S.[9] The Florida Act gives primary regulatory authority to the Florida Office of Financial Regulation (OFR), and some enforcement authority to the Office of the Attorney General over out-of-state consumer debt collectors.[10] The Act defines "*consumer collection agency*" (CCA) as any debt collector or business entity engaged in the business of soliciting consumer debts for collection or of collecting consumer debts. CCAs must register with the OFR, unless expressly exempted by the Act.[11] The OFR may also examine and investigate potential violations of the Act, and may impose administrative fines of up to $10,000 for each count or offense and up to $1,000 per day of unregistered activity; may deny, suspend, or revoke CCA registration; may impose reprimand, cease and desist orders, and emergency suspension orders.[12]

The Act prohibits many of the same debt collection practices prohibited by the federal Act, such as the use or threat to use force or violence, impersonating law enforcement or attorneys, communicating between 9 p.m. and 8 a.m. without the debtor's consent, and the disclosure of the debtor's debt except for legitimate purposes such as credit reporting agencies. However, Florida law does not specifically prohibit false, deceptive, or unfair practices the way the federal Act does.[13]

While the federal Act only applies to third-party debt collectors, Florida law provides that "no person shall" engage in the prohibited acts. As such, while the Florida act may exempt original creditors from registration with the OFR, original creditors may still be held liable (civilly and administratively) under Florida law for engaging in certain prohibited acts.

In terms of the federal Act's relation to Florida law, both acts were designed to work harmoniously, except to the extent state law conflicts with the federal Act.[14] The Act also provides that in the event of an inconsistency with the federal law, the provision which is more protective of the consumer or debtor shall prevail.[15] Finally, the Act provides that in construing its provisions, "due consideration and great

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[7] 15 U.S.C. 1692(e). The FDCPA is codified at 15 U.S.C. §§ 1692-1692p.
[8] Pub. L. 111-201, 124 Stat. 1376.
[9] Ch. 72-81, Laws of Fla.
[10] s. 559.563, F.S.
[11] ss. 559.55(3) and 559.553, F.S.
[12] ss. 559.5541, 559.727, and 559.730, F.S.
[13] *See* 15 U.S.C. §§ 1692e and1692f.
[14] 15 U.S.C. § 1692n.
[15] s. 559.552, F.S.

weight shall be given to the interpretations of the Federal Trade Commission and the federal courts relating to the federal Fair Debt Collection Practices Act."[16] The Act also does not preclude any person from pursuing remedies under the federal Act for any violation.[17]

Civil Remedies

The Act provides private civil remedies to debtors that are identical to those available under its federal counterpart.[18] Any person who violates the prohibited practices statute, s. 559.72, F.S., is liable to the consumer for actual and additional statutory damages up to $1,000 and reasonable attorney's fees and costs. In determining whether any additional statutory damages should be awarded to the debtor, the court may consider the nature of the defendant's noncompliance with s. 559.72, F.S., the frequency and persistence of the noncompliance, and the extent to which the noncompliance was intentional. The Act also permits class action suits and punitive damages in certain instances.

However, if the court finds that the debtor-plaintiff's suit fails to raise a justiciable issue of law or fact, the debtor-plaintiff is liable for court costs and reasonable attorney's fees incurred by the defendant.[19] Also, both acts provide a safe harbor for "bona fide errors," in that a person may not be held liable in any civil action under the acts if the person shows by a preponderance of the evidence that the violation was not intentional and resulted from a bona fide error, notwithstanding the maintenance of procedures reasonably adapted to avoid such error.

Prohibited Communications with Represented Debtors

Florida law prohibits any person from communicating with a debtor if the person *knows* that the debtor is represented by an attorney with respect to such debt, and has knowledge of or can readily ascertain such attorney's name and address. Federal law also prohibits such communication, although it applies only to debt collectors.[20] Courts have generally interpreted this provision as requiring *actual* knowledge by the debt collector of the debtor's representation by legal counsel in order for a communication with a debtor to constitute a violation.[21]

Both acts contain three identical exceptions to this prohibited communication:

- The debtor's attorney fails to respond within 30 days to a communication from the person,
- The debtor's attorney consents to a direct communication with the debtor, or
- The debtor initiates the communication.

Original creditors and debt collectors in Florida have indicated that the Act's applicability to "any person" has resulted in abusive or frivolous litigation arising from alleged violations of this provision. Industry representatives have noted current problems in the industry:

- Some law firms send vague notices of representation via facsimile to creditors and debt collectors, which raise two concerns: (1) questions of receipt and (2) questions regarding to the scope of representation.[22]
- Original creditors, such as hospitals, have noted that the statute does not clearly state how the debtor is required to provide notification that he or she has retained an attorney, and has exposed them to litigation merely for sending an invoice to a debtor-patient.[23]

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[16] s. 559.77(5), F.S.
[17] s. 559.730(8), F.S.
[18] 15 U.S.C. §1692k.
[19] s. 559.77, F.S. and 15 U.S.C. § 1692k.
[20] 15 U.S.C. § 1692c(a)(2).
[21] *Erickson v. General Elec. Co.*, 854 F.Supp.2d 1178, 1181-1182 (M.D. Fla. 2012); *Bacelli v. MFP, Inc.*, 729 F.Supp.2d 1328, 1343 (M.D. Fla. 2010). In another industry context, "actual knowledge" of a person's representation by legal counsel is also the standard applied to Florida Bar lawyers who are otherwise generally prohibited from communicating with represented persons. Florida Bar Rule of Professional Conduct § 4-4.2 and Preamble: Terminology.
[22] FLORIDA COLLECTORS ASSOCIATION, *White Paper: Attorney Representation of Consumers Under the Florida Consumer Collection Practices Act – 559.72(18)*, on file with the Insurance & Banking Subcommittee staff.

As such, proponents have advocated for statutory clarification of how debtors and their attorneys should communicate the legal representation to creditors and debt collectors so that they have the requisite "knowledge" of the representation. Consumer advocates argue that current law already provides substantial protections for persons collecting debts and that requirements such as certified mail notifications place a greater burden and cost on consumers, because it requires the consumer and his or her attorney to ascertain the address for the person collecting the debt (which is the address the person "designates to receive regarding the debt" and may be buried in fine print), and also requires notice by certified mail to this address, which is an additional cost to the consumer.[24]

Effect of the Proposed Committee Substitute (PCS)

The PCS amends s. 559.72(18), F.S., to clarify how a debtor or his or her attorney may provide notice of representation by legal counsel, by:

- Providing that the *debtor*, individually, may notify such person (i.e., the original creditor or debt collector) of the legal representation by way of any reasonable means, including verbal notices.
- Providing that the debtor's attorney may notify the original creditor that he or she represents the debtor with respect to such debt through one of three means:
  - Service of pleadings in a filed action,
  - Written notice of representation by certified mail to the original creditor's registered agent, which states that the debtor is represented by an attorney with respect to such debt and which discloses the attorney's name and address; or
  - Providing written notice of representation by mail, fax, email, or other electronic format in a manner designated on a billing statement which discloses the debtor's representation with respect to such debt and the attorney's name and mailing address.

While the PCS creates notification procedures giving rise to a creditor's "knowledge" of a debtor's representation, they do not toll the debt or prevent a creditor from reporting the debt to a credit reporting agency or pursuing legal remedies. However, these procedures should provide more clarity to creditors and debt collectors in avoiding liability and may reduce possible overreaching, interference, and uncounseled disclosure of information by creditors and debt collectors.

The PCS also retains the three exceptions in current law, regarding debtor-initiated communications, direct communications with the debtor consented to by the debtor's attorney, and communications to which the debtor's attorney does not respond within 30 days.

Secondly, the PCS creates s. 559.72(20), F.S., to prohibit any person from using false representation or deceptive or unfair means to collect or attempt to collect any debt or to obtain information concerning a consumer. As described above, similar prohibitions exist in the federal Act.

B. SECTION DIRECTORY:

Section 1. Amends s. 552.72, F.S., relating to prohibited practices generally.

Section 2. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

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[23] BAYCARE, *Proposed Florida Consumer Collection Practices Act (FCCPA) Reform* (Jan. 22, 2016) and Florida Hospital Government Relations, *Florida's Consumer Collection Practices Act* (Dec. 18, 2015), on file with the Insurance & Banking Subcommittee staff.

[24] FLORIDA ALLIANCE FOR CONSUMER PROTECTION, *White Paper: Consumer Debt Collection* (Dec. 30, 2015), on file with the Insurance & Banking Subcommittee staff.

Indeterminate. The extent of administrative fines that could be assessed and civil cases initiated as a result of the new prohibited practice is unknown.

2. Expenditures:

   See above.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. The PCS's clarification of prohibited communications with represented debtors may result in positive impact to original creditors and debt collectors, and the new prohibition on false, deceptive, or unfair collection practices may provide greater protection for consumers.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The PCS does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None provided by the PCS.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to consumer debt collection; amending
3 s. 557.72, F.S.; revising provisions relating to
4 communication with a debtor who is represented by an
5 attorney; specifying methods by which an attorney
6 representing a debtor may provide notice of such
7 representation; prohibiting false representations or
8 deceptive or unfair debt collection practices;
9 providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Subsection (18) of section 559.72, Florida
14 Statutes, is amended, and subsection (20) is created to read:
15 559.72 Prohibited practices generally.—In collecting
16 consumer debts, no person shall:
17 (18) Communicate with a debtor if the person has knowledge
18 ~~knows~~ that the debtor is represented by an attorney with respect
19 to such debt and has knowledge of, or can readily ascertain,
20 such attorney's name and address. A debtor, individually, may
21 notify such person of attorney representation by way of any
22 reasonable means, including verbal notice.
23 (a) This subsection does not apply if: ~~, unless~~
24 1. The debtor's attorney fails to respond within 30 days
25 to a communication from the person; ~~, unless~~
26 2. The debtor's attorney consents to a direct

27 communication with the debtor;~~,~~ or
28 3. ~~unless~~ The debtor initiates the communication.
29 (b) A debtor's attorney may notify the original creditor
30 that the debtor is represented by an attorney with respect to
31 such debt by:
32 1. Service of pleadings in a filed action;
33 2. Providing written notice of representation by certified
34 mail to the registered agent of the original creditor which
35 states that the debtor is represented by an attorney with
36 respect to such debt and which discloses the attorney's name and
37 address; or
38 3. Providing written notice of representation by mail,
39 fax, email, or other electronic format in a manner designated by
40 the original creditor on a billing statement which states that
41 the debtor is represented by an attorney with respect to such
42 debt, and which discloses the attorney's name and mailing
43 address.
44 (20) Use any false representation or deceptive or unfair
45 means to collect or attempt to collect any debt or to obtain
46 information concerning a consumer.
47 Section 2. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 879 Organization of the Department of Financial Services
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** SB 908

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Lloyd	Luczynski

SUMMARY ANALYSIS

The Chief Financial Officer (CFO) is an elected member of the Cabinet, serves as the chief fiscal officer of the State of Florida and is designated as the State Fire Marshal. The CFO is the head of the Department of Financial Services (DFS). Current law establishes 14 divisions of the DFS. They are the Divisions of: Accounting and Auditing; Administration; Consumer Services; Funeral, Cemetery, and Consumer Services; Information Systems; Insurance Agent and Agency Services; Insurance Fraud; Legal Services; Public Assistance Fraud; Rehabilitation and Liquidation; Risk Management; State Fire Marshal; Treasury; and Workers' Compensation. The bill reorganizes the DFS, as follows:

- Eliminates the following divisions: Administration; Legal Services; and Information Systems;
- Renames the Division of Insurance Fraud as the Division of Investigative and Forensic Services (DIFS);
- Creates the Bureau of Fire and Arson Investigations and Bureau of Forensic Services within DIFS; they will perform powers, duties and functions that are transferred from the Division of State Fire Marshal to the State Fire Marshal or DFS, generally, or to the DIFS, specifically;
- Changes an appointee to the Joint Task Force on State Agency Law Enforcement Communications from one representing the Division of State Fire Marshal to one representing DIFS and shifts the appointing authority from the State Fire Marshal to the CFO;
- Renames the Bureau of Unclaimed Property as the Division of Unclaimed Property (retaining all of its current powers, duties and functions);
- Eliminates the Office of Fiscal Integrity and shifts its powers, duties and functions to the DIFS;
- Relocates the statutory reference to the powers, duties and functions of the Division of Consumer Services, but the Division's powers, duties and functions remain the same; and
- Revises relevant statutes to reflect reorganization of DFS as made by the substantive portions of the bill.

There are no powers, duties or functions that are created or deleted by the bill; rather, they are either reallocated to a successor unit or reassigned to the DFS or the CFO or State Fire Marshal, generally.

The bill has no fiscal impact on state or local government expenditures. The bill does not impact the private sector.

The bill is effective July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Statutory Divisions, Duties and Functions of the Department of Financial Services

The Chief Financial Officer (CFO) is an elected member of the Cabinet, serves as the chief fiscal officer of the State of Florida[1] and is designated as the State Fire Marshal.[2] The CFO is the head of the Department of Financial Services (DFS). Effective January 2003, the Department of Insurance, Treasury, State Fire Marshal and the Department of Banking and Finance merged into DFS. DFS consists of many divisions and several specialized offices.[3]

The various departments of the executive branch receive their statutory powers, duties and functions either in a general grant of authority to either the department head or the department by name or by a specific grant with reference to a particular named unit. The department head has discretion when allocating or reallocating those powers, duties and functions that are assigned to them or their department in a general manner. If the powers, duties and functions are specifically assigned to a particular unit by statute, they cannot be reallocated by the department head. Rather, they must be reallocated by subsequent legislative enactment. There are similar limitations regarding the allocation and reallocation of existing organizational units or the establishment of new ones, including a restriction on establishing new divisions.[4]

Section 20.121, F.S., establishes 14 divisions of the DFS. They are the Divisions of:

- Accounting and Auditing;[5]
- Administration;
- Consumer Services;
- Funeral, Cemetery, and Consumer Services;
- Information Systems;
- Insurance Agent and Agency Services;
- Insurance Fraud;
- Legal Services;
- Public Assistance Fraud;
- Rehabilitation and Liquidation;
- Risk Management;
- State Fire Marshal;
- Treasury; and
- Workers' Compensation.[6]

Division of Accounting and Auditing

The mission of the Division of Accounting and Auditing is to safeguard public assets, settle the state's financial obligations, report financial information, and improve accountability of the state.[7] The Division

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[1] FLA. CONST. art. IV, s. 4.
[2] s. 633.104(1), F.S. Where applicable, references to the CFO in this bill analysis include the CFO's role as State Fire Marshal.
[3] s. 20.121, F.S.
[4] s. 20.04, F.S. When initiating the creation or reorganization of business units for DMS approval, the DFS is not required to adhere to the conventional terminology of "divisions," "bureaus," "sections," and the like.
[5] s. 20.121(2)(a), F.S. The Division of Accounting and Auditing includes the Bureau of Unclaimed Property, which receives reports and transfers of unclaimed property, and the Office of Fiscal Integrity, which functions as a criminal justice agency that investigates allegations of fraud, waste and abuse of state monies and resources.
[6] s. 20.121(2), F.S. Other statutory units of the DFS include the Bureau of Deferred Compensation, Office of Insurance Consumer Advocate and the Strategic Markets Research and Assessment Unit.

includes the Bureau of Unclaimed Property and the Office of Fiscal Integrity. It is also empowered by statute to "examine, audit, adjust, and settle the accounts of all the officers of this state, and any other person in anywise entrusted with, or who may have received any property, funds, or moneys of this state, or who may be in anywise indebted or accountable to this state for any property, funds, or moneys, and require such officer or persons to render full accounts thereof, and to yield up such property or funds according to law, or pay such moneys into the treasury of this state, or to such officer or agent of the state as may be appointed to receive the same, and on failure so to do, to cause to be instituted and prosecuted proceedings, criminal or civil, at law or in equity, against such persons, according to law."[8] In executing this power, the Division has the authority to conduct investigations, as necessary inside and outside of the state, and refer any suspected criminal conduct to the appropriate law enforcement and prosecutorial agency.

Bureau of Unclaimed Property

Unclaimed property constitutes any funds or other property, tangible or intangible, that has remained unclaimed by the owner for a certain number of years. Unclaimed property may include savings and checking accounts, money orders, travelers' checks, uncashed payroll or cashiers' checks, stocks, bonds, other securities, insurance policy payments, refunds, security and utility deposits, and contents of safe deposit boxes.[9]

In 1987, Florida adopted the Uniform Unclaimed Property Act and enacted the Florida Disposition of Unclaimed Property Act (ch. 717, F.S., "the Act").[10] The Act serves to protect the interests of missing owners of property, while the state derives a benefit from the unclaimed and abandoned property until the property is claimed, if ever. Under the Act, the Bureau of Unclaimed Property is responsible for receiving property, attempting to locate the rightful owners, and returning the property or proceeds to them. There is no statute of limitations in the Act, and citizens may claim their property, or the value of that property after liquidation as authorized by the Act, at any time and at no cost.

Generally, all intangible property, including any income less any lawful charges, which is held in the ordinary course of the holder's business, is presumed to be unclaimed when the owner fails to claim the property for more than five years after the property becomes payable or distributable, unless otherwise provided in the Act.[11] Holders of unclaimed property (which typically include banks and insurance companies) of $50 or more are required to use due diligence to locate and notify apparent owners of inactive accounts, at least 60 days but not more than 120 days prior to filing a report with the DFS.[12] If the owners cannot be located, holders must file an annual report with the DFS for all property, valued at $50 or more, that is presumed unclaimed for the preceding year.[13] The report must contain certain identifying information, such as the apparent owner's name, social security number or federal employer identification number, and last known address of apparent owners.[14] The holder must deliver all reportable unclaimed property to the DFS when it submits its annual report.[15]

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[7] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Accounting & Auditing*, http://www.myfloridacfo.com/Division/AA/ (last visited Jan. 26, 2016).
[8] s. 17.04, F.S.
[9] ss. 717.104 – 717.116, F.S.
[10] Ch. 87-105, Laws of Fla. See also UNIFORM LAW COMMISSION, *Unclaimed Property Act Summary*, http://www.uniformlaws.org/ActSummary.aspx?title=Unclaimed%20Property%20Act (last visited Jan. 26, 2016).
[11] s. 717.102(1), F.S.
[12] s. 717.117(4), F.S.
[13] s. 717.117, F.S.
[14] For unclaimed funds owing under any life or endowment insurance policy or annuity contract, the report must also include the last known address of the insured or annuitant and of the beneficiary according to records of the insurance company holding or owing the funds. s. 717.117(1)(b), F.S.
[15] s. 717.119, F.S.

Upon the payment or delivery of unclaimed property to DFS, the state assumes custody and responsibility for the safekeeping of the property.[16] The original property owner retains the right to recover the proceeds of the property, and any person claiming an interest in the property delivered to the DFS may file a claim for the property, subject to certain requirements.[17] The DFS is required to make a determination on a claim within 90 days. If a claim is determined in favor of the claimant, the DFS is to deliver or pay over to the claimant the property or the amount the DFS actually received or the proceeds, if it has been sold by the DFS.[18]

If the property remains unclaimed, it is liquidated and the proceeds are deposited into the Unclaimed Property Trust Fund.[19] The DFS is authorized to retain up to $15 million in the Unclaimed Property Trust Fund to make prompt payment of verified claims and to cover costs incurred by the DFS in administering and enforcing the Act. Excess funds in the Unclaimed Property Trust Fund are paid into the State School Trust Fund for investment and generation of income to benefit education in the state.[20]

Office of Fiscal Integrity

The Office of Fiscal Integrity (OFI) is a criminal justice agency within the DFS whose mission is to detect and investigate the misappropriation or misuse of state assets. The OFI performs functions related to the duty of the CFO to examine, audit, adjust, and settle the accounts of all state officers and any other person who has received state funds or moneys.[21] The OFI has sworn law enforcement officers on staff to conduct investigations or provide investigative assistance to other law enforcement agencies.[22]

Division of Insurance Fraud

The Division of Insurance Fraud investigates various types of insurance fraud including Personal Injury Protection (PIP) fraud, workers' compensation fraud, vehicle fraud, application fraud, licensee fraud, homeowner's insurance fraud, and healthcare fraud.[23] The Division is directed by statute to investigate fraudulent insurance acts, violations of the Unfair Insurance Trade Practices Act,[24] false and fraudulent insurance claims,[25] and willful violations of the Florida Insurance Code[26] and rules adopted pursuant to the code.[27] The Division employs sworn law enforcement officers to investigate insurance fraud. In Fiscal Year 2014-2015, the division received 17,392 referrals.[28]

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[16] s. 717.1201, F.S. Like many other states' unclaimed property acts, the Act is based on the common-law doctrine of escheat and is a "custody" statute, rather than a "title" statute, in that the DFS does not take title to abandoned property, but instead obtains its custody and beneficial use pending identification of the property owner.
[17] ss. 717.117 and 717.124, F.S.
[18] s. 717.124, F.S.
[19] s. 717.123, F.S.
[20] *Id.*
[21] s. 17.04, F.S.
[22] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Accounting & Auditing*, http://www.myfloridacfo.com/Division/AA/StateAgencies/OfficeofFiscalIntegrity.htm (last visited Jan. 26, 2016).
[23] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Accounting & Auditing*, http://www.myfloridacfo.com/division/fraud/ (last visited Jan. 26, 2016).
[24] s. 626.9541, F.S.
[25] s. 817.234, F.S.
[26] Chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S., constitute the "Florida Insurance Code." s. 624.01, F.S.
[27] s. 624.15, F.S.
[28] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, *Division of Insurance Fraud Annual Report Fiscal Year 2014-2015*, p. 4, http://www.myfloridacfo.com/division/fraud/documents/2014-15_Annual-Report.pdf (last visited Jan. 26, 2016).

Division of Consumer Services

The Division of Consumer Services deals with consumer issues and complaints related to the jurisdiction of the DFS and the Office of Insurance Regulation (OIR). The Division:

- Receives inquiries and complaints from consumers;
- Prepares and disseminates information as the DFS deems appropriate to inform or assist consumers;
- Provides direct assistance and advocacy for consumers; and
- Reports potential violations of law or applicable rules by a person or entity licensed by the DFS or the OIR to appropriate division within DFS or the OIR, as appropriate.[29]

Division of the State Fire Marshal

Chapter 633, F.S., governs fire prevention and control in the state. Section 633.104, F.S., designates the CFO as the State Fire Marshal. The CFO implements the duties of State Fire Marshal and ch. 633, F.S., through the Division of the State Fire Marshal. Pursuant to this authority, the Division regulates, trains, and certifies fire service personnel, investigates the causes of fires, enforces arson laws, regulates the installation of fire equipment, conducts firesafety inspections of state property, develops firesafety standards, provides facilities for the analysis of fire debris, and operates the Florida State Fire College.

Effect of the Bill

The bill eliminates the Division of Administration, the Division of Legal Services, and the Division of Information Systems. According to DFS, these divisions all conduct administrative functions that every state agency has and are not required to be provided for in statute. These divisions do not have any specific statutory powers, duties and functions. They implement the general authority of the CFO.

The bill removes the Bureau of Unclaimed Property and the Office of Fiscal Integrity (OFI) from the Division of Accounting and Auditing. The Division of Auditing and Accounting continues to exist, without specific subunits or powers, duties and functions being provided for in statute. The Bureau of Unclaimed Property becomes the Division of Unclaimed Property and retains all of its current powers, duties and functions. The OFI's powers, duties and functions are transferred to the Division of Investigative and Forensic Services. While reference to the OFI is removed from statute, its powers, duties and functions will continue to be utilized.

The Division of Insurance Fraud is renamed the Division of Investigative and Forensic Services (DIFS). The Bureau of Fire and Arson Investigations and the Bureau of Forensic Services are created within DIFS. While these two bureaus do not receive any specific powers, duties and functions under the bill, the DFS reports that they will perform the powers, duties and functions within ch. 633, F.S., which the bill transfers from the Division of State Fire Marshal to the State Fire Marshal or DFS, generally, or to the DIFS, specifically. Those powers, duties and functions that are given to the State Fire Marshal or DFS as a general assignment can subsequently be reallocated at the discretion of the State Fire Marshal.[30] The DFS states that it will reallocate 131 full time equivalency positions from the Division of State Fire Marshal to DIFS upon the bill becoming effective.[31] The establishment of DIFS by the bill effectively consolidates all of the law enforcement and related support units in the DFS into a single division.

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[29] s. 20.121(2)(h), F.S.
[30] s. 20.04(7)(a), F.S.
[31] FLORIDA DEPARTMENT OF FINANCIAL SERVICES, Agency Analysis of 2016 HB 879, p. 2 (Jan. 7, 2016). The process of formalizing such a reallocation of positions involves filings with the Department of Management Services and the Legislative Budget Commission and would occur subsequent to the effective date of the bill, if passed.

Currently, a representative of the Division of State Fire Marshal, appointed by the State Fire Marshal, serves on the Joint Task Force on State Agency Law Enforcement Communications. Since DFS law enforcement personnel are consolidated within DIFS, the bill changes the appointee from a representative of the Division of State Fire Marshal to one representing DIFS and the appointing authority from the State Fire Marshal to the CFO.

The bill relocates the statutory reference to the powers, duties and functions of the Division of Consumer Services from s. 20.121(2), F.S., which addresses the organizational structure of DFS to s. 624.307, F.S., which describes the general powers and the duties of DFS. The Division's powers, duties and functions remain the same.

There are no powers, duties or functions that are created or deleted by the bill; rather, they are either reallocated to a successor unit or reassigned to the DFS or the CFO or State Fire Marshal, generally.

B. SECTION DIRECTORY:

Section 1. Amends s. 17.04, F.S., relating to certain investigatory powers of the Division of Accounting and Auditing.

Section 2. Amends s. 17.0401, F.S., making the CFO responsible for maintaining the confidential and exempt nature of certain public records, rather than the Division of Accounting and Auditing.

Section 3. Amends s. 20.021, F.S., relating to the required business units of the DFS and certain powers, duties and functions of these units.

Section 4. Amends s. 624.26, F.S., eliminating a cross-reference.

Section 5. Amends s. 624.307, F.S., relating to the relocation of powers and duties of the Division of Consumer Services that were formerly found in s. 20.121(2)(h), F.S.

Sections 6 through 25. Amend s. 16.59, F.S., s. 400.9935, F.S., s. 409.91212, F.S., s. 440.105, F.S., s. 440.1051, s. 440.12, F.S., s. 624.521, F.S., s. 626.016, F.S., s. 626.989, F.S., s. 626.9891, F.S., s. 626.9892, F.S., s. 626.9893, F.S., s. 626.9894, F.S., s. 626.99278, F.S., s. 627.351, F.S., s. 627.711, F.S., s. 627.736, F.S., s. 627.7401, F.S., s. 631.156, F.S., and s. 641.30, F.S., relating to the renaming of the Division of Insurance Fraud as the DIFS.

Sections 26 through 30. Amend s. 282.709, F.S., s. 552.113, F.S., s. 552.21, F.S., s. 633.112, F.S., and s. 633.114, F.S., relating to the transfer of certain powers, duties, and functions from the Division of State Fire Marshal to the DIFS, the DFS, State Fire Marshal, or CFO.

Sections 31 through 37. Amend s. 633.122, F.S., s. 633.126, F.S., s. 633.422, F.S., s. 633.508, F.S., s. 633.512, F.S., s. 633.518, F.S., and s. 791.013, F.S., relating to the transfer of certain powers, duties, and functions from the Division of State Fire Marshal to the DIFS, the DFS, or State Fire Marshal.

Sections 38 through 43. Amend s. 538.32, F.S., s. 717.1241, F.S., s. 717.1323, F.S., s. 717.135, F.S., s. 717.1351, F.S., and s. 717.1400, F.S., relating to the renaming of the Bureau of Unclaimed Property to the Division of Unclaimed Property.

Section 44. Amends s. 932.7055, F.S., relating to the transfer of certain powers, duties, and functions from the Division of State Fire Marshal to the DIFS.

Section 45. Provides an effective date of July 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to organization of the Department of
3 Financial Services; amending ss. 17.04 and 17.0401,
4 F.S.; authorizing the Chief Financial Officer, rather
5 than the Division of Accounting and Auditing, to audit
6 and adjust accounts of officers and those indebted to
7 the state; making conforming changes; reordering and
8 amending s. 20.121, F.S.; revising the divisions and
9 the location of bureaus within the divisions; revising
10 the functions of the department; providing duties for
11 the Division of Investigative and Forensic Services;
12 amending s. 624.26, F.S.; conforming a provision to
13 changes made by the act; amending s. 624.307, F.S.;
14 providing powers and duties of the Division of
15 Consumer Services; authorizing the division to impose
16 certain penalties; authorizing the department to adopt
17 rules relating to the division; providing for
18 construction; amending ss. 16.59, 400.9935, 409.91212,
19 440.105, 440.1051, 440.12, 624.521, 626.016, 626.989,
20 626.9891, 626.9892, 626.9893, 626.9894, 626.99278,
21 627.351, 627.711, 627.736, 627.7401, 631.156, and
22 641.30, F.S., relating to the renaming of the Division
23 of Insurance Fraud; conforming provisions to changes
24 made by the act; making technical changes; amending
25 ss. 282.709, 552.113, 552.21, 633.112, 633.114,
26 633.126, 633.422, 633.508, 633.512, 633.518, and

27 791.013, F.S., relating to the transfer of certain
28 functions to the Division of Investigative and
29 Forensic Services; conforming provisions to changes
30 made by the act; amending ss. 538.32, 717.1241,
31 717.1323, 717.135, 717.1351, and 717.1400, F.S.,
32 relating to the renaming of the Bureau of Unclaimed
33 Property; conforming provisions to changes made by the
34 act; making technical changes; amending s. 932.7055,
35 F.S.; conforming provisions to changes made by the
36 act; providing an effective date.
37
38 Be It Enacted by the Legislature of the State of Florida:
39
40 Section 1. Section 17.04, Florida Statutes, is amended to
41 read:
42 17.04 To audit and adjust accounts of officers and those
43 indebted to the state.—The Chief Financial Officer, using
44 generally accepted auditing procedures for testing or sampling,
45 shall examine, audit, adjust, and settle the accounts of all the
46 officers of this state, and any other person in anywise
47 entrusted with, or who may have received any property, funds, or
48 moneys of this state, or who may be in anywise indebted or
49 accountable to this state for any property, funds, or moneys,
50 and require such officer or persons to render full accounts
51 thereof, and to yield up such property or funds according to
52 law, or pay such moneys into the treasury of this state, or to

53 such officer or agent of the state as may be appointed to
54 receive the same, and on failure so to do, to cause to be
55 instituted and prosecuted proceedings, criminal or civil, at law
56 or in equity, against such persons, according to law. The Chief
57 Financial Officer ~~Division of Accounting and Auditing~~ may
58 conduct investigations within or outside of this state as it
59 deems necessary to aid in the enforcement of this section. If
60 during an investigation the Chief Financial Officer ~~division~~ has
61 reason to believe that any criminal statute of this state has or
62 may have been violated, the Chief Financial Officer ~~division~~
63 shall refer any records tending to show such violation to state
64 or federal law enforcement or prosecutorial agencies and shall
65 provide investigative assistance to those agencies as required.
66 Section 2. Section 17.0401, Florida Statutes, is amended
67 to read:
68 17.0401 Confidentiality of information relating to
69 financial investigations.—Except as otherwise provided by this
70 section, information relative to an investigation conducted by
71 the Chief Financial Officer ~~Division of Accounting and Auditing~~
72 pursuant to s. 17.04, including any consumer complaint, is
73 confidential and exempt from the provisions of s. 119.07(1) and
74 s. 24(a), Art. I of the State Constitution until the
75 investigation is completed or ceases to be active. Any
76 information relating to an investigation conducted ~~by the~~
77 ~~division~~ pursuant to s. 17.04 shall remain confidential and
78 exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I

79 of the State Constitution after the ~~division's~~ investigation is
80 completed or ceases to be active if the Chief Financial Officer
81 ~~division~~ submits the information to any law enforcement or
82 prosecutorial agency for further investigation. Such information
83 shall remain confidential and exempt from the provisions of s.
84 119.07(1) and s. 24(a), Art. I of the State Constitution until
85 that agency's investigation is completed or ceases to be active.
86 For purposes of this section, an investigation shall be
87 considered "active" so long as the Chief Financial Officer
88 ~~division~~ or any law enforcement or prosecutorial agency is
89 proceeding with reasonable dispatch and has a reasonable good
90 faith belief that the investigation may lead to the filing of an
91 administrative, civil, or criminal proceeding. This section
92 shall not be construed to prohibit disclosure of information
93 that is required by law to be filed with the Department of
94 Financial Services or the Office of Financial Regulation and
95 that, but for the investigation, would otherwise be subject to
96 public disclosure. Nothing in this section shall be construed to
97 prohibit the Chief Financial Officer ~~division~~ from providing
98 information to any law enforcement or prosecutorial agency. Any
99 law enforcement or prosecutorial agency receiving confidential
100 information from the Chief Financial Officer ~~division~~ in
101 connection with its official duties shall maintain the
102 confidentiality of the information as provided for in this
103 section.
104 Section 3. Subsection (2) of section 20.121, Florida

105 Statutes, is reordered and amended, to read:
106 20.121 Department of Financial Services.—There is created
107 a Department of Financial Services.
108 (2) DIVISIONS.—The Department of Financial Services shall
109 consist of the following divisions and office:
110 (a) The Division of Accounting and Auditing~~, which shall~~
111 ~~include the following bureau and office:~~
112 ~~1. The Bureau of Unclaimed Property.~~
113 ~~2. The Office of Fiscal Integrity which shall function as~~
114 ~~a criminal justice agency for purposes of ss. 943.045-943.08 and~~
115 ~~shall have a separate budget. The office may conduct~~
116 ~~investigations within or outside this state as the bureau deems~~
117 ~~necessary to aid in the enforcement of this section. If during~~
118 ~~an investigation the office has reason to believe that any~~
119 ~~criminal law of this state has or may have been violated, the~~
120 ~~office shall refer any records tending to show such violation to~~
121 ~~state or federal law enforcement or prosecutorial agencies and~~
122 ~~shall provide investigative assistance to those agencies as~~
123 ~~required~~.
124 (i)~~(b)~~ The Division of State Fire Marshal.
125 (h)~~(c)~~ The Division of Risk Management.
126 (j)~~(d)~~ The Division of Treasury, which shall include a
127 Bureau of Deferred Compensation responsible for administering
128 the Government Employees Deferred Compensation Plan established
129 under s. 112.215 for state employees.
130 (k) The Division of Unclaimed Property.

131 (e) The Division of Investigative and Forensic Services,
132 which shall include the Bureau of Forensic Services and the
133 Bureau of Fire and Arson Investigations, and which shall
134 function as a criminal justice agency for purposes of ss.
135 943.045-943.08. The division may conduct investigations within
136 or outside of this state as it deems necessary. If, during an
137 investigation, the division has reason to believe that any
138 criminal law of this state has or may have been violated, it
139 shall refer any records tending to show such violation to state
140 or federal law enforcement or prosecutorial agencies and shall
141 provide investigative assistance to those agencies as required
142 ~~Insurance Fraud~~.
143 (g) ~~(f)~~ The Division of Rehabilitation and Liquidation.
144 (d) ~~(g)~~ The Division of Insurance Agent and Agency
145 Services.
146 (b) ~~(h)~~ The Division of Consumer Services.
147 ~~1. The Division of Consumer Services shall perform the~~
148 ~~following functions concerning products or services regulated by~~
149 ~~the department or by the Office of Insurance Regulation:~~
150 ~~a. Receive inquiries and complaints from consumers.~~
151 ~~b. Prepare and disseminate such information as the~~
152 ~~department deems appropriate to inform or assist consumers.~~
153 ~~c. Provide direct assistance and advocacy for consumers~~
154 ~~who request such assistance or advocacy.~~
155 ~~d. With respect to apparent or potential violations of law~~
156 ~~or applicable rules by a person or entity licensed by the~~

157 ~~department or office, report apparent or potential violations to~~
158 ~~the office or the appropriate division of the department, which~~
159 ~~may take such further action as it deems appropriate.~~
160 ~~c. Designate an employee of the division as primary~~
161 ~~contact for consumers on issues relating to sinkholes.~~
162 ~~2. Any person licensed or issued a certificate of~~
163 ~~authority by the department or by the Office of Insurance~~
164 ~~Regulation shall respond, in writing, to the Division of~~
165 ~~Consumer Services within 20 days after receipt of a written~~
166 ~~request for information from the division concerning a consumer~~
167 ~~complaint. The response must address the issues and allegations~~
168 ~~raised in the complaint. The division may impose an~~
169 ~~administrative penalty for failure to comply with this~~
170 ~~subparagraph of up to $2,500 per violation upon any entity~~
171 ~~licensed by the department or the office and $250 for the first~~
172 ~~violation, $500 for the second violation, and up to $1,000 per~~
173 ~~violation thereafter upon any individual licensed by the~~
174 ~~department or the office.~~
175 ~~3. The department may adopt rules to administer this~~
176 ~~paragraph.~~
177 ~~4. The powers, duties, and responsibilities expressed or~~
178 ~~granted in this paragraph do not limit the powers, duties, and~~
179 ~~responsibilities of the Department of Financial Services, the~~
180 ~~Financial Services Commission, the Office of Insurance~~
181 ~~Regulation, or the Office of Financial Regulation set forth~~
182 ~~elsewhere in the Florida Statutes.~~

183 (l) ~~(i)~~ The Division of Workers' Compensation.
184 ~~(j) The Division of Administration.~~
185 ~~(k) The Division of Legal Services.~~
186 ~~(l) The Division of Information Systems.~~
187 (m) The Office of Insurance Consumer Advocate.
188 (c) ~~(n)~~ The Division of Funeral, Cemetery, and Consumer
189 Services.
190 (f) ~~(o)~~ The Division of Public Assistance Fraud.
191 Section 4. Subsection (4) of section 624.26, Florida
192 Statutes, is amended to read:
193 624.26 Collaborative arrangement with the Department of
194 Health and Human Services.—
195 (4) The department's Division of Consumer Services may
196 respond to complaints by consumers relating to a requirement of
197 PPACA ~~as authorized under s. 20.121(2)(h),~~ and report apparent
198 or potential violations to the office and to the federal
199 Department of Health and Human Services.
200 Section 5. Subsection (10) is added to section 624.307,
201 Florida Statutes, to read:
202 624.307 General powers; duties.—
203 (10)(a) The Division of Consumer Services shall perform
204 the following functions concerning products or services
205 regulated by the department or office:
206 1. Receive inquiries and complaints from consumers.
207 2. Prepare and disseminate information that the department
208 deems appropriate to inform or assist consumers.

209 3. Provide direct assistance to and advocacy for consumers
210 who request such assistance or advocacy.
211 4. With respect to apparent or potential violations of law
212 or applicable rules committed by a person or entity licensed by
213 the department or office, report apparent or potential
214 violations to the office or to the appropriate division of the
215 department, which may take any additional action it deems
216 appropriate.
217 5. Designate an employee of the division as the primary
218 contact for consumers on issues relating to sinkholes.
219 (b) Any person licensed or issued a certificate of
220 authority by the department or the office shall respond, in
221 writing, to the division within 20 days after receipt of a
222 written request for information from the division concerning a
223 consumer complaint. The response must address the issues and
224 allegations raised in the complaint. The division may impose an
225 administrative penalty for failure to comply with this paragraph
226 of up to $2,500 per violation upon any entity licensed by the
227 department or the office and $250 for the first violation, $500
228 for the second violation, and up to $1,000 for the third or
229 subsequent violation upon any individual licensed by the
230 department or the office.
231 (c) The department may adopt rules to administer this
232 subsection.
233 (d) The powers, duties, and responsibilities expressed or
234 granted in this subsection do not limit the powers, duties, and

235 responsibilities of the department, the Financial Services
236 Commission, the Office of Insurance Regulation, or the Office of
237 Financial Regulation as otherwise provided by law.
238 Section 6. Section 16.59, Florida Statutes, is amended to
239 read:
240 16.59 Medicaid fraud control.—The Medicaid Fraud Control
241 Unit is created in the Department of Legal Affairs to
242 investigate all violations of s. 409.920 and any criminal
243 violations discovered during the course of those investigations.
244 The Medicaid Fraud Control Unit may refer any criminal violation
245 so uncovered to the appropriate prosecuting authority. The
246 offices of the Medicaid Fraud Control Unit, the Agency for
247 Health Care Administration Medicaid program integrity program,
248 and the Divisions of Investigative and Forensic Services
249 ~~Insurance Fraud~~ and Public Assistance Fraud within the
250 Department of Financial Services shall, to the extent possible,
251 be collocated; however, positions dedicated to Medicaid managed
252 care fraud within the Medicaid Fraud Control Unit shall be
253 collocated with the Division of Investigative and Forensic
254 Services ~~Insurance Fraud~~. The Agency for Health Care
255 Administration, the Department of Legal Affairs, and the
256 Divisions of Investigative and Forensic Services ~~Insurance Fraud~~
257 and Public Assistance Fraud within the Department of Financial
258 Services shall conduct joint training and other joint activities
259 designed to increase communication and coordination in
260 recovering overpayments.

261 Section 7. Subsection (9) of section 400.9935, Florida
262 Statutes, is amended to read:
263 400.9935 Clinic responsibilities.—
264 (9) In addition to the requirements of part II of chapter
265 408, the clinic shall display a sign in a conspicuous location
266 within the clinic readily visible to all patients indicating
267 that, pursuant to s. 626.9892, the Department of Financial
268 Services may pay rewards of up to $25,000 to persons providing
269 information leading to the arrest and conviction of persons
270 committing crimes investigated by the Division of Investigative
271 and Forensic Services ~~Insurance Fraud~~ arising from violations of
272 s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.
273 An authorized employee of the Division of Investigative and
274 Forensic Services ~~Insurance Fraud~~ may make unannounced
275 inspections of a clinic licensed under this part as necessary to
276 determine whether the clinic is in compliance with this
277 subsection. A licensed clinic shall allow full and complete
278 access to the premises to such authorized employee of the
279 division who makes an inspection to determine compliance with
280 this subsection.
281 Section 8. Subsection (6) of section 409.91212, Florida
282 Statutes, is amended to read:
283 409.91212 Medicaid managed care fraud.—
284 (6) Each managed care plan shall report all suspected or
285 confirmed instances of provider or recipient fraud or abuse
286 within 15 calendar days after detection to the Office of

287 Medicaid Program Integrity within the agency. At a minimum the
288 report must contain the name of the provider or recipient, the
289 Medicaid billing number or tax identification number, and a
290 description of the fraudulent or abusive act. The Office of
291 Medicaid Program Integrity in the agency shall forward the
292 report of suspected overpayment, abuse, or fraud to the
293 appropriate investigative unit, including, but not limited to,
294 the Bureau of Medicaid program integrity, the Medicaid fraud
295 control unit, the Division of Public Assistance Fraud, the
296 Division of Investigative and Forensic Services ~~Insurance Fraud~~,
297 or the Department of Law Enforcement.
298 (a) Failure to timely report shall result in an
299 administrative fine of $1,000 per calendar day after the 15th
300 day of detection.
301 (b) Failure to timely report may result in additional
302 administrative, civil, or criminal penalties.
303 Section 9. Paragraph (a) of subsection (1) of section
304 440.105, Florida Statutes, is amended to read:
305 440.105 Prohibited activities; reports; penalties;
306 limitations.—
307 (1)(a) Any insurance carrier, any individual self-insured,
308 any commercial or group self-insurance fund, any professional
309 practitioner licensed or regulated by the Department of Health,
310 except as otherwise provided by law, any medical review
311 committee as defined in s. 766.101, any private medical review
312 committee, and any insurer, agent, or other person licensed

313 under the insurance code, or any employee thereof, having
314 knowledge or who believes that a fraudulent act or any other act
315 or practice which, upon conviction, constitutes a felony or
316 misdemeanor under this chapter is being or has been committed
317 shall send to the Division of Investigative and Forensic
318 Services ~~Insurance Fraud~~, Bureau of Workers' Compensation Fraud,
319 a report or information pertinent to such knowledge or belief
320 and such additional information relative thereto as the bureau
321 may require. The bureau shall review such information or reports
322 and select such information or reports as, in its judgment, may
323 require further investigation. It shall then cause an
324 independent examination of the facts surrounding such
325 information or report to be made to determine the extent, if
326 any, to which a fraudulent act or any other act or practice
327 which, upon conviction, constitutes a felony or a misdemeanor
328 under this chapter is being committed. The bureau shall report
329 any alleged violations of law which its investigations disclose
330 to the appropriate licensing agency and state attorney or other
331 prosecuting agency having jurisdiction with respect to any such
332 violations of this chapter. If prosecution by the state attorney
333 or other prosecuting agency having jurisdiction with respect to
334 such violation is not begun within 60 days of the bureau's
335 report, the state attorney or other prosecuting agency having
336 jurisdiction with respect to such violation shall inform the
337 bureau of the reasons for the lack of prosecution.
338 Section 10. Subsections (1) and (2) of section 440.1051,

339 Florida Statutes, are amended to read:
340 440.1051 Fraud reports; civil immunity; criminal
341 penalties.—
342 (1) The Bureau of Workers' Compensation Insurance Fraud of
343 the Division of Investigative and Forensic Services ~~Insurance~~
344 ~~Fraud~~ of the department shall establish a toll-free telephone
345 number to receive reports of workers' compensation fraud
346 committed by an employee, employer, insurance provider,
347 physician, attorney, or other person.
348 (2) Any person who reports workers' compensation fraud to
349 the Division of Investigative and Forensic Services ~~Insurance~~
350 ~~Fraud~~ under subsection (1) is immune from civil liability for
351 doing so, and the person or entity alleged to have committed the
352 fraud may not retaliate against him or her for providing such
353 report, unless the person making the report knows it to be
354 false.
355 Section 11. Paragraph (c) of subsection (1) of section
356 440.12, Florida Statutes, is amended to read:
357 440.12 Time for commencement and limits on weekly rate of
358 compensation.—
359 (1) Compensation is not allowed for the first 7 days of
360 the disability, except for benefits provided under s. 440.13.
361 However, if the injury results in more than 21 days of
362 disability, compensation is allowed from the commencement of the
363 disability.
364 (c) Each carrier shall keep a record of all payments made

365 under this subsection, including the time and manner of such
366 payments, and shall furnish these records or a report based on
367 these records to the Division of Investigative and Forensic
368 Services ~~Insurance Fraud~~ and the Division of Workers'
369 Compensation, upon request.
370 Section 12. Subsection (1) of section 624.521, Florida
371 Statutes, is amended to read:
372 624.521 Deposit of certain tax receipts; refund of
373 improper payments.—
374 (1) The department ~~of Financial Services~~ shall promptly
375 deposit in the State Treasury to the credit of the Insurance
376 Regulatory Trust Fund all "state tax" portions of agents'
377 licenses collected under s. 624.501 necessary to fund the
378 Division of Investigative and Forensic Services ~~Insurance Fraud~~.
379 The balance of the tax shall be credited to the General Fund.
380 All moneys received by the department ~~of Financial Services~~ or
381 the office not in accordance with ~~the provisions of~~ this code or
382 not in the exact amount as specified by the applicable
383 provisions of this code shall be returned to the remitter. The
384 records of the department or office shall show the date and
385 reason for such return.
386 Section 13. Subsection (4) of section 626.016, Florida
387 Statutes, is amended to read:
388 626.016 Powers and duties of department, commission, and
389 office.—
390 (4) ~~Nothing in~~ This section is not intended to limit the

391 authority of the department and the Division of Investigative
392 and Forensic Services ~~Insurance Fraud~~, as specified in s.
393 626.989.
394 Section 14. Section 626.989, Florida Statutes, is amended
395 to read:
396 626.989 Investigation by department or Division of
397 Investigative and Forensic Services ~~Insurance Fraud~~; compliance;
398 immunity; confidential information; reports to division;
399 division investigator's power of arrest.—
400 (1) For the purposes of this section:
401 (a) A person commits a "fraudulent insurance act" if the
402 person:
403 1. Knowingly and with intent to defraud presents, causes
404 to be presented, or prepares with knowledge or belief that it
405 will be presented, to or by an insurer, self-insurer, self-
406 insurance fund, servicing corporation, purported insurer,
407 broker, or any agent thereof, any written statement as part of,
408 or in support of, an application for the issuance of, or the
409 rating of, any insurance policy, or a claim for payment or other
410 benefit pursuant to any insurance policy, which the person knows
411 to contain materially false information concerning any fact
412 material thereto or if the person conceals, for the purpose of
413 misleading another, information concerning any fact material
414 thereto.
415 2. Knowingly submits:
416 a. A false, misleading, or fraudulent application or other

417 document when applying for licensure as a health care clinic,
418 seeking an exemption from licensure as a health care clinic, or
419 demonstrating compliance with part X of chapter 400 with an
420 intent to use the license, exemption from licensure, or
421 demonstration of compliance to provide services or seek
422 reimbursement under the Florida Motor Vehicle No-Fault Law.
423 b. A claim for payment or other benefit pursuant to a
424 personal injury protection insurance policy under the Florida
425 Motor Vehicle No-Fault Law if the person knows that the payee
426 knowingly submitted a false, misleading, or fraudulent
427 application or other document when applying for licensure as a
428 health care clinic, seeking an exemption from licensure as a
429 health care clinic, or demonstrating compliance with part X of
430 chapter 400.
431 (b) The term "insurer" also includes a health maintenance
432 organization, and the term "insurance policy" also includes a
433 health maintenance organization subscriber contract.
434 (2) If, by its own inquiries or as a result of complaints,
435 the department or its Division of Investigative and Forensic
436 Services ~~Insurance Fraud~~ has reason to believe that a person has
437 engaged in, or is engaging in, a fraudulent insurance act, an
438 act or practice that violates s. 626.9541 or s. 817.234, or an
439 act or practice punishable under s. 624.15, it may administer
440 oaths and affirmations, request the attendance of witnesses or
441 proffering of matter, and collect evidence. The department or
442 its Division of Investigative and Forensic Services shall not

443 compel the attendance of any person or matter in any such
444 investigation except pursuant to subsection (4).
445 (3) If matter that the department or its division seeks to
446 obtain by request is located outside the state, the person so
447 requested may make it available to the division or its
448 representative to examine the matter at the place where it is
449 located. The division may designate representatives, including
450 officials of the state in which the matter is located, to
451 inspect the matter on its behalf, and it may respond to similar
452 requests from officials of other states.
453 (4)(a) The department or its division may request that an
454 individual who refuses to comply with any such request be
455 ordered by the circuit court to provide the testimony or matter.
456 The court shall not order such compliance unless the department
457 or its division has demonstrated to the satisfaction of the
458 court that the testimony of the witness or the matter under
459 request has a direct bearing on the commission of a fraudulent
460 insurance act, on a violation of s. 626.9541 or s. 817.234, or
461 on an act or practice punishable under s. 624.15 or is pertinent
462 and necessary to further such investigation.
463 (b) Except in a prosecution for perjury, an individual who
464 complies with a court order to provide testimony or matter after
465 asserting a privilege against self-incrimination to which the
466 individual is entitled by law may not be subjected to a criminal
467 proceeding or to a civil penalty with respect to the act
468 concerning which the individual is required to testify or

469 produce relevant matter.
470 (c) In the absence of fraud or bad faith, a person is not
471 subject to civil liability for libel, slander, or any other
472 relevant tort by virtue of filing reports, without malice, or
473 furnishing other information, without malice, required by this
474 section or required by the department or division under the
475 authority granted in this section, and no civil cause of action
476 of any nature shall arise against such person:
477 1. For any information relating to suspected fraudulent
478 insurance acts or persons suspected of engaging in such acts
479 furnished to or received from law enforcement officials, their
480 agents, or employees;
481 2. For any information relating to suspected fraudulent
482 insurance acts or persons suspected of engaging in such acts
483 furnished to or received from other persons subject to the
484 provisions of this chapter;
485 3. For any such information furnished in reports to the
486 department, the division, the National Insurance Crime Bureau,
487 the National Association of Insurance Commissioners, or any
488 local, state, or federal enforcement officials or their agents
489 or employees; or
490 4. For other actions taken in cooperation with any of the
491 agencies or individuals specified in this paragraph in the
492 lawful investigation of suspected fraudulent insurance acts.
493 (d) In addition to the immunity granted in paragraph (c),
494 persons identified as designated employees whose

495 responsibilities include the investigation and disposition of
496 claims relating to suspected fraudulent insurance acts may share
497 information relating to persons suspected of committing
498 fraudulent insurance acts with other designated employees
499 employed by the same or other insurers whose responsibilities
500 include the investigation and disposition of claims relating to
501 fraudulent insurance acts, provided the department has been
502 given written notice of the names and job titles of such
503 designated employees prior to such designated employees sharing
504 information. Unless the designated employees of the insurer act
505 in bad faith or in reckless disregard for the rights of any
506 insured, neither the insurer nor its designated employees are
507 civilly liable for libel, slander, or any other relevant tort,
508 and a civil action does not arise against the insurer or its
509 designated employees:
510 1. For any information related to suspected fraudulent
511 insurance acts provided to an insurer; or
512 2. For any information relating to suspected fraudulent
513 insurance acts provided to the National Insurance Crime Bureau
514 or the National Association of Insurance Commissioners.
515
516 Provided, however, that the qualified immunity against civil
517 liability conferred on any insurer or its designated employees
518 shall be forfeited with respect to the exchange or publication
519 of any defamatory information with third persons not expressly
520 authorized by this paragraph to share in such information.

521 (e) The Chief Financial Officer and any employee or agent
522 of the department, commission, office, or division, when acting
523 without malice and in the absence of fraud or bad faith, is not
524 subject to civil liability for libel, slander, or any other
525 relevant tort, and no civil cause of action of any nature exists
526 against such person by virtue of the execution of official
527 activities or duties of the department, commission, or office
528 under this section or by virtue of the publication of any report
529 or bulletin related to the official activities or duties of the
530 department, division, commission, or office under this section.
531 (f) This section does not abrogate or modify in any way
532 any common-law or statutory privilege or immunity heretofore
533 enjoyed by any person.
534 (5) The office's and the department's papers, documents,
535 reports, or evidence relative to the subject of an investigation
536 under this section are confidential and exempt from the
537 provisions of s. 119.07(1) until such investigation is completed
538 or ceases to be active. For purposes of this subsection, an
539 investigation is considered "active" while the investigation is
540 being conducted by the office or department with a reasonable,
541 good faith belief that it could lead to the filing of
542 administrative, civil, or criminal proceedings. An investigation
543 does not cease to be active if the office or department is
544 proceeding with reasonable dispatch and has a good faith belief
545 that action could be initiated by the office or department or
546 other administrative or law enforcement agency. After an

547 investigation is completed or ceases to be active, portions of
548 records relating to the investigation shall remain exempt from
549 the provisions of s. 119.07(1) if disclosure would:
550 (a) Jeopardize the integrity of another active
551 investigation;
552 (b) Impair the safety and soundness of an insurer;
553 (c) Reveal personal financial information;
554 (d) Reveal the identity of a confidential source;
555 (e) Defame or cause unwarranted damage to the good name or
556 reputation of an individual or jeopardize the safety of an
557 individual; or
558 (f) Reveal investigative techniques or procedures.
559 Further, such papers, documents, reports, or evidence relative
560 to the subject of an investigation under this section shall not
561 be subject to discovery until the investigation is completed or
562 ceases to be active. Office, department, or division
563 investigators shall not be subject to subpoena in civil actions
564 by any court of this state to testify concerning any matter of
565 which they have knowledge pursuant to a pending insurance fraud
566 investigation by the division.
567 (6) Any person, other than an insurer, agent, or other
568 person licensed under the code, or an employee thereof, having
569 knowledge or who believes that a fraudulent insurance act or any
570 other act or practice which, upon conviction, constitutes a
571 felony or a misdemeanor under the code, or under s. 817.234, is
572 being or has been committed may send to the Division of

573 Investigative and Forensic Services ~~Insurance Fraud~~ a report or
574 information pertinent to such knowledge or belief and such
575 additional information relative thereto as the department may
576 request. Any professional practitioner licensed or regulated by
577 the Department of Business and Professional Regulation, except
578 as otherwise provided by law, any medical review committee as
579 defined in s. 766.101, any private medical review committee, and
580 any insurer, agent, or other person licensed under the code, or
581 an employee thereof, having knowledge or who believes that a
582 fraudulent insurance act or any other act or practice which,
583 upon conviction, constitutes a felony or a misdemeanor under the
584 code, or under s. 817.234, is being or has been committed shall
585 send to the Division of Investigative and Forensic Services
586 ~~Insurance Fraud~~ a report or information pertinent to such
587 knowledge or belief and such additional information relative
588 thereto as the department may require. The Division of
589 Investigative and Forensic Services ~~Insurance Fraud~~ shall review
590 such information or reports and select such information or
591 reports as, in its judgment, may require further investigation.
592 It shall then cause an independent examination of the facts
593 surrounding such information or report to be made to determine
594 the extent, if any, to which a fraudulent insurance act or any
595 other act or practice which, upon conviction, constitutes a
596 felony or a misdemeanor under the code, or under s. 817.234, is
597 being committed. The Division of Investigative and Forensic
598 Services ~~Insurance Fraud~~ shall report any alleged violations of

599 law which its investigations disclose to the appropriate
600 licensing agency and state attorney or other prosecuting agency
601 having jurisdiction with respect to any such violation, as
602 provided in s. 624.310. If prosecution by the state attorney or
603 other prosecuting agency having jurisdiction with respect to
604 such violation is not begun within 60 days of the division's
605 report, the state attorney or other prosecuting agency having
606 jurisdiction with respect to such violation shall inform the
607 division of the reasons for the lack of prosecution.
608 (7) Division investigators shall have the power to make
609 arrests for criminal violations established as a result of
610 investigations. Such investigators shall also be considered
611 state law enforcement officers for all purposes and shall have
612 the power to execute arrest warrants and search warrants; to
613 serve subpoenas issued for the examination, investigation, and
614 trial of all offenses; and to arrest upon probable cause without
615 warrant any person found in the act of violating any of the
616 provisions of applicable laws. Investigators empowered to make
617 arrests under this section shall be empowered to bear arms in
618 the performance of their duties. In such a situation, the
619 investigator must be certified in compliance with the provisions
620 of s. 943.1395 or must meet the temporary employment or
621 appointment exemption requirements of s. 943.131 until
622 certified.
623 (8) It is unlawful for any person to resist an arrest
624 authorized by this section or in any manner to interfere, either

625 by abetting or assisting such resistance or otherwise
626 interfering, with division investigators in the duties imposed
627 upon them by law or department rule.
628 (9) In recognition of the complementary roles of
629 investigating instances of workers' compensation fraud and
630 enforcing compliance with the workers' compensation coverage
631 requirements under chapter 440, the Department of Financial
632 Services shall prepare and submit a joint performance report to
633 the President of the Senate and the Speaker of the House of
634 Representatives by January 1 of each year. The annual report
635 must include, but need not be limited to:
636 (a) The total number of initial referrals received, cases
637 opened, cases presented for prosecution, cases closed, and
638 convictions resulting from cases presented for prosecution by
639 the Bureau of Workers' Compensation Insurance Fraud by type of
640 workers' compensation fraud and circuit.
641 (b) The number of referrals received from insurers and the
642 Division of Workers' Compensation and the outcome of those
643 referrals.
644 (c) The number of investigations undertaken by the Bureau
645 of Workers' Compensation Insurance Fraud which were not the
646 result of a referral from an insurer or the Division of Workers'
647 Compensation.
648 (d) The number of investigations that resulted in a
649 referral to a regulatory agency and the disposition of those
650 referrals.

651 (e) The number and reasons provided by local prosecutors
652 or the statewide prosecutor for declining prosecution of a case
653 presented by the Bureau of Workers' Compensation Insurance Fraud
654 by circuit.
655 (f) The total number of employees assigned to the Bureau
656 of Workers' Compensation Insurance Fraud and the Division of
657 Workers' Compensation Bureau of Compliance delineated by
658 location of staff assigned; and the number and location of
659 employees assigned to the Bureau of Workers' Compensation
660 Insurance Fraud who were assigned to work other types of fraud
661 cases.
662 (g) The average caseload and turnaround time by type of
663 case for each investigator and division compliance employee.
664 (h) The training provided during the year to workers'
665 compensation fraud investigators and the division's compliance
666 employees.
667 Section 15. Subsections (1), (2), and (3) of section
668 626.9891, Florida Statutes, are amended to read:
669 626.9891 Insurer anti-fraud investigative units; reporting
670 requirements; penalties for noncompliance.—
671 (1) Every insurer admitted to do business in this state
672 who in the previous calendar year, at any time during that year,
673 had $10 million or more in direct premiums written shall:
674 (a) Establish and maintain a unit or division within the
675 company to investigate possible fraudulent claims by insureds or
676 by persons making claims for services or repairs against

677 policies held by insureds; or
678 (b) Contract with others to investigate possible
679 fraudulent claims for services or repairs against policies held
680 by insureds.
681
682 An insurer subject to this subsection shall file with the
683 Division of Investigative and Forensic Services ~~Insurance Fraud~~
684 of the department on or before July 1, 1996, a detailed
685 description of the unit or division established pursuant to
686 paragraph (a) or a copy of the contract and related documents
687 required by paragraph (b).
688 (2) Every insurer admitted to do business in this state,
689 which in the previous calendar year had less than $10 million in
690 direct premiums written, must adopt an anti-fraud plan and file
691 it with the Division of Investigative and Forensic Services
692 ~~Insurance Fraud~~ of the department on or before July 1, 1996. An
693 insurer may, in lieu of adopting and filing an anti-fraud plan,
694 comply with the provisions of subsection (1).
695 (3) Each insurers anti-fraud plans shall include:
696 (a) A description of the insurer's procedures for
697 detecting and investigating possible fraudulent insurance acts;
698 (b) A description of the insurer's procedures for the
699 mandatory reporting of possible fraudulent insurance acts to the
700 Division of Investigative and Forensic Services ~~Insurance Fraud~~
701 of the department;
702 (c) A description of the insurer's plan for anti-fraud

703 education and training of its claims adjusters or other
704 personnel; and
705 (d) A written description or chart outlining the
706 organizational arrangement of the insurer's anti-fraud personnel
707 who are responsible for the investigation and reporting of
708 possible fraudulent insurance acts.
709 Section 16. Subsection (2) of section 626.9892, Florida
710 Statutes, is amended to read:
711 626.9892 Anti-Fraud Reward Program; reporting of insurance
712 fraud.—
713 (2) The department may pay rewards of up to $25,000 to
714 persons providing information leading to the arrest and
715 conviction of persons committing crimes investigated by the
716 Division of Investigative and Forensic Services ~~Insurance Fraud~~
717 arising from violations of s. 440.105, s. 624.15, s. 626.9541,
718 s. 626.989, or s. 817.234.
719 Section 17. Subsection (1) of section 626.9893, Florida
720 Statutes, is amended to read:
721 626.9893 Disposition of revenues; criminal or forfeiture
722 proceedings.—
723 (1) The Division of Investigative and Forensic Services
724 ~~Insurance Fraud~~ of the Department of Financial Services may
725 deposit revenues received as a result of criminal proceedings or
726 forfeiture proceedings, other than revenues deposited into the
727 Department of Financial Services' Federal Law Enforcement Trust
728 Fund under s. 17.43, into the Insurance Regulatory Trust Fund.

729 Moneys deposited pursuant to this section shall be separately
730 accounted for and shall be used solely for the division to carry
731 out its duties and responsibilities.
732 Section 18. Subsection (2) of section 626.9894, Florida
733 Statutes, is amended to read:
734 626.9894 Gifts and grants.—
735 (2) All rights to, interest in, and title to such donated
736 or granted property shall immediately vest in the Division of
737 Investigative and Forensic Services ~~Insurance Fraud~~ upon
738 donation. The division may hold such property in coownership,
739 sell its interest in the property, liquidate its interest in the
740 property, or dispose of its interest in the property in any
741 other reasonable manner.
742 Section 19. Section 626.99278, Florida Statutes, is
743 amended to read:
744 626.99278 Viatical provider anti-fraud plan.—Every
745 licensed viatical settlement provider and registered life
746 expectancy provider must adopt an anti-fraud plan and file it
747 with the Division of Investigative and Forensic Services
748 ~~Insurance Fraud~~ of the department. Each anti-fraud plan shall
749 include:
750 (1) A description of the procedures for detecting and
751 investigating possible fraudulent acts and procedures for
752 resolving material inconsistencies between medical records and
753 insurance applications.
754 (2) A description of the procedures for the mandatory

755 reporting of possible fraudulent insurance acts and prohibited
756 practices set forth in s. 626.99275 to the Division of
757 Investigative and Forensic Services ~~Insurance Fraud~~ of the
758 department.
759 (3) A description of the plan for anti-fraud education and
760 training of its underwriters or other personnel.
761 (4) A written description or chart outlining the
762 organizational arrangement of the anti-fraud personnel who are
763 responsible for the investigation and reporting of possible
764 fraudulent insurance acts and for the investigation of
765 unresolved material inconsistencies between medical records and
766 insurance applications.
767 (5) For viatical settlement providers, a description of
768 the procedures used to perform initial and continuing review of
769 the accuracy of life expectancies used in connection with a
770 viatical settlement contract or viatical settlement investment.
771 Section 20. Paragraph (k) of subsection (6) of section
772 627.351, Florida Statutes, is amended to read:
773 627.351 Insurance risk apportionment plans.—
774 (6) CITIZENS PROPERTY INSURANCE CORPORATION.—
775 (k)1. The corporation shall establish and maintain a unit
776 or division to investigate possible fraudulent claims by
777 insureds or by persons making claims for services or repairs
778 against policies held by insureds; or it may contract with
779 others to investigate possible fraudulent claims for services or
780 repairs against policies held by the corporation pursuant to s.

781 626.9891. The corporation must comply with reporting
782 requirements of s. 626.9891. An employee of the corporation
783 shall notify the corporation's Office of the Inspector General
784 and the Division of Investigative and Forensic Services
785 ~~Insurance Fraud~~ within 48 hours after having information that
786 would lead a reasonable person to suspect that fraud may have
787 been committed by any employee of the corporation.
788 2. The corporation shall establish a unit or division
789 responsible for receiving and responding to consumer complaints,
790 which unit or division is the sole responsibility of a senior
791 manager of the corporation.
792 Section 21. Subsections (4) and (7) of section 627.711,
793 Florida Statutes, are amended to read:
794 627.711 Notice of premium discounts for hurricane loss
795 mitigation; uniform mitigation verification inspection form.—
796 (4) An authorized mitigation inspector that signs a
797 uniform mitigation form, and a direct employee authorized to
798 conduct mitigation verification inspections under subsection
799 ~~paragraph~~ (3), may not commit misconduct in performing hurricane
800 mitigation inspections or in completing a uniform mitigation
801 form that causes financial harm to a customer or their insurer;
802 or that jeopardizes a customer's health and safety. Misconduct
803 occurs when an authorized mitigation inspector signs a uniform
804 mitigation verification form that:
805 (a) Falsely indicates that he or she personally inspected
806 the structures referenced by the form;

807 (b) Falsely indicates the existence of a feature which
808 entitles an insured to a mitigation discount which the inspector
809 knows does not exist or did not personally inspect;
810 (c) Contains erroneous information due to the gross
811 negligence of the inspector; or
812 (d) Contains a pattern of demonstrably false information
813 regarding the existence of mitigation features that could give
814 an insured a false evaluation of the ability of the structure to
815 withstand major damage from a hurricane endangering the safety
816 of the insured's life and property.
817 (7) An insurer, person, or other entity that obtains
818 evidence of fraud or evidence that an authorized mitigation
819 inspector or an employee authorized to conduct mitigation
820 verification inspections under subsection ~~paragraph~~ (3) has made
821 false statements in the completion of a mitigation inspection
822 form shall file a report with the Division of Investigative and
823 Forensic Services ~~Insurance Fraud~~, along with all of the
824 evidence in its possession that supports the allegation of fraud
825 or falsity. An insurer, person, or other entity making the
826 report shall be immune from liability, in accordance with s.
827 626.989(4), for any statements made in the report, during the
828 investigation, or in connection with the report. The Division of
829 Investigative and Forensic Services ~~Insurance Fraud~~ shall issue
830 an investigative report if it finds that probable cause exists
831 to believe that the authorized mitigation inspector, or an
832 employee authorized to conduct mitigation verification

833 inspections under subsection ~~paragraph~~ (3), made intentionally
834 false or fraudulent statements in the inspection form. Upon
835 conclusion of the investigation and a finding of probable cause
836 that a violation has occurred, the Division of Investigative and
837 Forensic Services ~~Insurance Fraud~~ shall send a copy of the
838 investigative report to the office and a copy to the agency
839 responsible for the professional licensure of the authorized
840 mitigation inspector, whether or not a prosecutor takes action
841 based upon the report.
842 Section 22. Paragraph (i) of subsection (4) and subsection
843 (14) of section 627.736, Florida Statutes, are amended to read:
844 627.736 Required personal injury protection benefits;
845 exclusions; priority; claims.—
846 (4) PAYMENT OF BENEFITS.—Benefits due from an insurer
847 under ss. 627.730-627.7405 are primary, except that benefits
848 received under any workers' compensation law must be credited
849 against the benefits provided by subsection (1) and are due and
850 payable as loss accrues upon receipt of reasonable proof of such
851 loss and the amount of expenses and loss incurred which are
852 covered by the policy issued under ss. 627.730-627.7405. If the
853 Agency for Health Care Administration provides, pays, or becomes
854 liable for medical assistance under the Medicaid program related
855 to injury, sickness, disease, or death arising out of the
856 ownership, maintenance, or use of a motor vehicle, the benefits
857 under ss. 627.730-627.7405 are subject to the Medicaid program.
858 However, within 30 days after receiving notice that the Medicaid

859 program paid such benefits, the insurer shall repay the full
860 amount of the benefits to the Medicaid program.
861 (i) If an insurer has a reasonable belief that a
862 fraudulent insurance act, for the purposes of s. 626.989 or s.
863 817.234, has been committed, the insurer shall notify the
864 claimant, in writing, within 30 days after submission of the
865 claim that the claim is being investigated for suspected fraud.
866 Beginning at the end of the initial 30-day period, the insurer
867 has an additional 60 days to conduct its fraud investigation.
868 Notwithstanding subsection (10), no later than 90 days after the
869 submission of the claim, the insurer must deny the claim or pay
870 the claim with simple interest as provided in paragraph (d).
871 Interest shall be assessed from the day the claim was submitted
872 until the day the claim is paid. All claims denied for suspected
873 fraudulent insurance acts shall be reported to the Division of
874 Investigative and Forensic Services ~~Insurance Fraud~~.
875 (14) FRAUD ADVISORY NOTICE.—Upon receiving notice of a
876 claim under this section, an insurer shall provide a notice to
877 the insured or to a person for whom a claim for reimbursement
878 for diagnosis or treatment of injuries has been filed, advising
879 that:
880 (a) Pursuant to s. 626.9892, the Department of Financial
881 Services may pay rewards of up to $25,000 to persons providing
882 information leading to the arrest and conviction of persons
883 committing crimes investigated by the Division of Investigative
884 and Forensic Services ~~Insurance Fraud~~ arising from violations of

885 s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.
886 (b) Solicitation of a person injured in a motor vehicle
887 crash for purposes of filing personal injury protection or tort
888 claims could be a violation of s. 817.234, s. 817.505, or the
889 rules regulating The Florida Bar and should be immediately
890 reported to the Division of Investigative and Forensic Services
891 ~~Insurance Fraud~~ if such conduct has taken place.
892 Section 23. Paragraphs (b) and (c) of subsection (1) of
893 section 627.7401, Florida Statutes, are amended to read:
894 627.7401 Notification of insured's rights.—
895 (1) The commission, by rule, shall adopt a form for the
896 notification of insureds of their right to receive personal
897 injury protection benefits under the Florida Motor Vehicle No-
898 Fault Law. Such notice shall include:
899 (b) An advisory informing insureds that:
900 1. Pursuant to s. 626.9892, the Department of Financial
901 Services may pay rewards of up to $25,000 to persons providing
902 information leading to the arrest and conviction of persons
903 committing crimes investigated by the Division of Investigative
904 and Forensic Services ~~Insurance Fraud~~ arising from violations of
905 s. 440.105, s. 624.15, s. 626.9541, s. 626.989, or s. 817.234.
906 2. Pursuant to s. 627.736(5)(e)1., if the insured notifies
907 the insurer of a billing error, the insured may be entitled to a
908 certain percentage of a reduction in the amount paid by the
909 insured's motor vehicle insurer.
910 (c) A notice that solicitation of a person injured in a

911 motor vehicle crash for purposes of filing personal injury
912 protection or tort claims could be a violation of s. 817.234, s
913 817.505, or the rules regulating The Florida Bar and should be
914 immediately reported to the Division of Investigative and
915 Forensic Services ~~Insurance Fraud~~ if such conduct has taken
916 place.
917 Section 24. Subsection (2) of section 631.156, Florida
918 Statutes, is amended to read:
919 631.156 Investigation by the department; scope of
920 authority; sharing of materials.—
921 (2) The department may provide documents, books, and
922 records; other investigative products, work product, and
923 analysis; and copies of any or all of such materials to the
924 Division of Investigative and Forensic Services ~~Insurance Fraud~~
925 or any other appropriate government agency. The sharing of these
926 materials does ~~shall~~ not waive any work product or other
927 privilege otherwise applicable under law.
928 Section 25. Subsection (4) of section 641.30, Florida
929 Statutes, is amended to read:
930 641.30 Construction and relationship to other laws.—
931 (4) The Division of Investigative and Forensic Services
932 ~~Insurance Fraud~~ of the department is vested with all powers
933 granted to it under the Florida Insurance Code with respect to
934 the investigation of any violation of this part.
935 Section 26. Paragraph (a) of subsection (2) of section
936 282.709, Florida Statutes, is amended to read:

937 282.709 State agency law enforcement radio system and
938 interoperability network.—
939 (2) The Joint Task Force on State Agency Law Enforcement
940 Communications is created adjunct to the department to advise
941 the department of member-agency needs relating to the planning,
942 designing, and establishment of the statewide communication
943 system.
944 (a) The Joint Task Force on State Agency Law Enforcement
945 Communications shall consist of the following members:
946 1. A representative of the Division of Alcoholic Beverages
947 and Tobacco of the Department of Business and Professional
948 Regulation who shall be appointed by the secretary of the
949 department.
950 2. A representative of the Division of Florida Highway
951 Patrol of the Department of Highway Safety and Motor Vehicles
952 who shall be appointed by the executive director of the
953 department.
954 3. A representative of the Department of Law Enforcement
955 who shall be appointed by the executive director of the
956 department.
957 4. A representative of the Fish and Wildlife Conservation
958 Commission who shall be appointed by the executive director of
959 the commission.
960 5. A representative of the Department of Corrections who
961 shall be appointed by the secretary of the department.
962 6. A representative of the Division of Investigative and

963 Forensic Services ~~State Fire Marshal~~ of the Department of
964 Financial Services who shall be appointed by the Chief Financial
965 Officer ~~State Fire Marshal~~.
966 7. A representative of the Department of Agriculture and
967 Consumer Services who shall be appointed by the Commissioner of
968 Agriculture.
969 Section 27. Subsection (3) of section 552.113, Florida
970 Statutes, is amended to read:
971 552.113 Reports of thefts, illegal use, or illegal
972 possession.—
973 (3) The Division of Investigative and Forensic Services
974 shall investigate, or be certain that a qualified law
975 enforcement agency investigates, the cause and circumstances of
976 each theft, illegal use, or illegal possession of explosives
977 which occurs within the state. A report of each such
978 investigation shall be made and maintained by the Division of
979 Investigative and Forensic Services.
980 Section 28. Subsections (1) and (2) of section 552.21,
981 Florida Statutes, are amended to read:
982 552.21 Confiscation and disposal of explosives.—
983 (1) Whenever the department ~~division~~ shall have reason to
984 believe that any person is or has been violating the provisions
985 of this chapter or any rules or regulations adopted and
986 promulgated pursuant thereto, the department ~~division~~ may,
987 without further process of law, confiscate the explosives in
988 question and cause them to be stored in a safe manner, or, if

989 any explosives are deemed by the department ~~division~~ to be in
990 such a state or condition as to constitute a hazard to life or
991 property, the department ~~division~~ may dispose of such explosives
992 without further process of law. The department ~~division~~ is
993 authorized to dispose of any abandoned explosives that it deems
994 to be hazardous to life or property.
995 (2) If the person so charged is found guilty of violating
996 ~~the provisions of~~ this chapter or any rule or regulation adopted
997 pursuant thereto with regard to the possession, handling, or
998 storage of explosives, the department ~~division~~ is authorized to
999 dispose of the confiscated materials in such a way as it shall
1000 deem equitable.
1001 Section 29. Paragraph (c) of subsection (6) of section
1002 633.112, Florida Statutes, is amended to read:
1003 633.112 State Fire Marshal; hearings; investigations;
1004 recordkeeping and reports; subpoenas of witnesses; orders of
1005 circuit court.—
1006 (6) Upon request, the State Fire Marshal shall investigate
1007 the cause, origin, and circumstances of fires and explosions
1008 occurring in this state wherein property has been damaged or
1009 destroyed and there is probable cause to believe that the fire
1010 or explosion was the result of carelessness or design.
1011 (c) The State Fire Marshal ~~division~~ shall adopt rules to
1012 assist local fire officials and law enforcement officers in
1013 determining the established responsibilities with respect to the
1014 initial or preliminary assessment of fire and explosion scenes,

1015 and the determination of whether probable cause exists to refer
1016 such scenes to the State Fire Marshal for an investigation.
1017 Section 30. Subsection (1) of section 633.114, Florida
1018 Statutes, is amended to read:
1019 633.114 State Fire Marshal agents; authority; duties;
1020 compensation.—
1021 (1) The State Fire Marshal shall appoint such agents,
1022 including agents of the Division of Investigative and Forensic
1023 Services, as may be necessary to carry out effectively this
1024 chapter, who shall be reimbursed for travel expenses as provided
1025 in s. 112.061, in addition to their salary, when traveling or
1026 making investigations in the performance of their duties. Such
1027 agents, including agents of the Division of Investigative and
1028 Forensic Services, shall be at all times under the direction and
1029 control of the State Fire Marshal, who shall fix their
1030 compensation, and all orders shall be issued in the State Fire
1031 Marshal's name and by her or his authority.
1032 Section 31. Section 633.122, Florida Statutes, is amended
1033 to read: 633.122 Impersonating State Fire Marshal,
1034 firefighter, volunteer firefighter, or firesafety inspector;
1035 criminal penalties.—A person who falsely assumes or pretends to
1036 be the State Fire Marshal, an agent of the State Fire Marshal
1037 ~~division~~, a firefighter, a volunteer firefighter, or a
1038 firesafety inspector by identifying herself or himself as the
1039 State Fire Marshal, an agent of the State Fire Marshal ~~division~~,
1040 a firefighter, a volunteer firefighter, or a firesafety

1041 inspector by wearing a uniform or presenting or displaying a
1042 badge as credentials that would cause a reasonable person to
1043 believe that she or he is a State Fire Marshal, an agent of the
1044 State Fire Marshal ~~division~~, a firefighter, a volunteer
1045 firefighter, or firesafety inspector commits a felony of the
1046 third degree, punishable as provided in ss. 775.082 and 775.083
1047 or, if the impersonation occurs during the commission of a
1048 separate felony by that person, commits a felony of the first
1049 degree, punishable as provided in ss. 775.082 and 775.083.
1050
1051 Section 32. Paragraph (b) of subsection (1) of section
1052 633.126, Florida Statutes, is amended to read:
1053 633.126 Investigation of fraudulent insurance claims and
1054 crimes; immunity of insurance companies supplying information.—
1055 (1)
1056 (b) The State Fire Marshal or an agent appointed pursuant
1057 to s. 633.114, an agent of the Division of Investigative and
1058 Forensic Services, any law enforcement officer as defined in s.
1059 111.065, any law enforcement officer of a federal agency, or any
1060 fire service provider official who is engaged in the
1061 investigation of a fire or explosion loss may request any
1062 insurance company or its agent, adjuster, employee, or attorney,
1063 investigating a claim under an insurance policy or contract with
1064 respect to a fire or explosion to release any information
1065 whatsoever in the possession of the insurance company or its
1066 agent, adjuster, employee, or attorney relative to a loss from

1067 that fire or explosion. The insurance company shall release the
1068 available information to and cooperate with any official
1069 authorized to request such information pursuant to this section.
1070 The information shall include, but shall not be limited to:
1071 1. Any insurance policy relevant to a loss under
1072 investigation and any application for such a policy.
1073 2. Any policy premium payment records.
1074 3. The records, reports, and all material pertaining to
1075 any previous claims made by the insured with the reporting
1076 company.
1077 4. Material relating to the investigation of the loss,
1078 including statements of a person, proof of loss, and other
1079 relevant evidence.
1080 5. Memoranda, notes, and correspondence relating to the
1081 investigation of the loss in the possession of the insurance
1082 company or its agents, adjusters, employees, or attorneys.
1083 Section 33. Subsection (5) of section 633.422, Florida
1084 Statutes, is amended to read:
1085 633.422 Firefighters; supplemental compensation.—
1086 (5) APPLICABILITY.—For the purposes of this section, the
1087 department ~~division~~ shall be considered a fire service provider
1088 responsible for the payment of supplemental compensation in
1089 accordance with this section to firefighters employed full time
1090 by the department ~~division~~.
1091 Section 34. Subsection (7) of section 633.508, Florida
1092 Statutes, is amended to read:

1093 633.508 Workplace safety; rulemaking authority; division
1094 authority.—
1095 (7) The department ~~division~~ shall:
1096 (a) Investigate and prescribe by rule what safety devices,
1097 safeguards, or other means of protection must be adopted for the
1098 prevention of accidents and injuries in every firefighter
1099 employee place of employment or at any fire scene; determine
1100 what suitable devices, safeguards, or other means of protection
1101 for the prevention of occupational diseases must be adopted or
1102 followed in any or all such firefighter places of employment or
1103 at any emergency fire scene; and adopt reasonable rules for the
1104 prevention of accidents, the safety, protection, and security of
1105 firefighter employees engaged in interior firefighting, and the
1106 prevention of occupational diseases.
1107 (b) Ascertain, fix, and order such reasonable standards
1108 and rules for the construction, repair, and maintenance of
1109 firefighter employee places of employment so as to render them
1110 safe. Such rules and standards shall be adopted in accordance
1111 with chapter 120.
1112 (c) Adopt rules prescribing recordkeeping responsibilities
1113 for firefighter employers, which may include maintaining a log
1114 and summary of occupational injuries, diseases, and illnesses,
1115 for producing on request a notice of injury and firefighter
1116 employee accident investigation records, and prescribing a
1117 retention schedule for such records.
1118 Section 35. Section 633.512, Florida Statutes, is amended

1119 to read:
1120 633.512 Compliance.—Failure of a firefighter employer or
1121 an insurer to comply with this part, or with any rules adopted
1122 under this part, constitutes grounds for the department ~~division~~
1123 to seek remedies, including injunctive relief, by making
1124 appropriate filings with the circuit court.
1125 Section 36. Subsection (1) of section 633.518, Florida
1126 Statutes, is amended to read:
1127 633.518 Studies, investigations, inspections, or inquiries
1128 by the division; refusal to admit; penalty.—
1129 (1) The department ~~division~~ shall make studies,
1130 investigations, inspections, or inquiries with respect to
1131 compliance with this part or any rules authorized under this
1132 part and the causes of firefighter employee injuries, illnesses,
1133 safety-based complaints, or Line of Duty Deaths (LODD) as
1134 defined in rule in firefighter employee places of employment and
1135 shall make such recommendations to the Legislature and
1136 firefighter employers and insurers as the department ~~division~~
1137 considers proper to prevent or reduce future occurrences. In
1138 making such studies, investigations, inspections, or inquiries,
1139 the department ~~division~~ may cooperate with any agency of the
1140 United States charged with the duty of enforcing any law
1141 securing safety against injury in any place of firefighter
1142 employment covered by this part or any agency or department of
1143 the state engaged in enforcing any law to ensure safety for
1144 firefighter employees.

1145 Section 37. Subsection (3) of section 791.013, Florida
1146 Statutes, is amended to read:
1147 791.013 Testing and approval of sparklers; penalties.—
1148 (3) For purposes of the testing requirement by this
1149 section, the division shall perform such tests as are necessary
1150 to determine compliance with the performance standards in the
1151 definition of sparklers, pursuant to s. 791.01. The State Fire
1152 Marshal shall adopt, by rule, procedures for testing products to
1153 determine compliance with this chapter. The Division <u>of</u>
1154 <u>Investigative and Forensic Services</u> shall dispose of any samples
1155 which remain after testing.
1156 Section 38. Paragraphs (b), (c), and (d) of subsection (7)
1157 of section 538.32, Florida Statutes, are amended to read:
1158 538.32 Registration, transaction, and recordkeeping
1159 requirements; penalties.—
1160 (7)
1161 (b) Alternatively, a secondhand dealer must give written
1162 notice to the seller, by United States mail or e-mail if an e-
1163 mail address is provided by the seller, that information
1164 otherwise required to be given by the seller under subsection
1165 (2) has not been provided by the seller to the secondhand
1166 dealer. Notice of the deficient information must be sent by the
1167 secondhand dealer no later than 10 days after the transaction is
1168 received by the secondhand dealer. The secondhand dealer must
1169 specify in the notice that:
1170 1. The seller must provide the missing information or must

1171 request the return of the property from the secondhand dealer
1172 within 30 days after receiving the notice from the secondhand
1173 dealer; and
1174 2. The failure of the seller to provide the missing
1175 information or request return of the property within the
1176 applicable 30-day time period shall result in abandonment of the
1177 seller's property to the Division ~~Bureau~~ of Unclaimed Property
1178 of the Department of Financial Services pursuant to chapter 717.
1179 (c) If the seller fails to remedy the deficiency in
1180 information or request return of the property within 30 days
1181 after receiving the notice, the seller's property is deemed
1182 abandoned and is relinquished to the Division ~~Bureau~~ of
1183 Unclaimed Property pursuant to chapter 717 if the property's
1184 true market value is greater than $50 as defined in chapter 717.
1185 (d) Within 24 hours after the expiration of the 30-day
1186 hold period for the property, the secondhand dealer must notify
1187 the appropriate law enforcement agency of the abandonment of the
1188 property by electronic transmission or by sending a copy of the
1189 completed form authorized by chapter 717 to the Department of
1190 Financial Services, Division ~~Bureau~~ of Unclaimed Property.
1191 Section 39. Subsection (1) of section 717.1241, Florida
1192 Statutes, is amended to read:
1193 717.1241 Conflicting claims.—
1194 (1) When conflicting claims have been received by the
1195 department for the same unclaimed property account or accounts,
1196 the property shall be remitted in accordance with the claim

1197 filed by the person as follows, notwithstanding the withdrawal
1198 of a claim:
1199 (a) To the person submitting the first claim received by
1200 the Division ~~Bureau~~ of Unclaimed Property of the department that
1201 is complete or made complete.
1202 (b) If a claimant's claim and a claimant's
1203 representative's claim are received by the Division ~~Bureau~~ of
1204 Unclaimed Property of the department on the same day and both
1205 claims are complete, to the claimant.
1206 (c) If a buyer's claim and a claimant's claim or a
1207 claimant's representative's claim are received by the Division
1208 ~~Bureau~~ of Unclaimed Property of the department on the same day
1209 and the claims are complete, to the buyer.
1210 (d) As between two or more claimant's representative's
1211 claims received by the Division ~~Bureau~~ of Unclaimed Property of
1212 the department that are complete or made complete on the same
1213 day, to the claimant's representative who has agreed to receive
1214 the lowest fee. If the two or more claimant's representatives
1215 whose claims received by the Division ~~Bureau~~ of Unclaimed
1216 Property of the department were complete or made complete on the
1217 same day are charging the same lowest fee, the fee shall be
1218 divided equally between the claimant's representatives.
1219 (e) If more than one buyer's claim received by the
1220 Division ~~Bureau~~ of Unclaimed Property of the department is
1221 complete or made complete on the same day, the department shall
1222 remit the unclaimed property to the buyer who paid the highest

1223 amount to the seller. If the buyers paid the same amount to the
1224 seller, the department shall remit the unclaimed property to the
1225 buyers divided in equal amounts.
1226 Section 40. Section 717.1323, Florida Statutes, is amended
1227 to read:
1228 717.1323 Prohibited practice.—A ~~No~~ person may not
1229 knowingly enter false information onto the Internet website of
1230 the Division ~~Bureau~~ of Unclaimed Property.
1231 Section 41. Subsection (2) and paragraph (a) of subsection
1232 (3) of section 717.135, Florida Statutes, are amended to read:
1233 717.135 Power of attorney to recover reported property in
1234 the custody of the department.—
1235 (2) A power of attorney described in subsection (1) must:
1236 (a) Limit the fees and costs for services to 20 percent
1237 per unclaimed property account held by the department. Fees and
1238 costs for cash accounts shall be based on the value of the
1239 property at the time the power of attorney is signed by the
1240 claimant. Fees and costs for accounts containing securities or
1241 other intangible ownership interests, which securities or
1242 interests are not converted to cash, shall be based on the
1243 purchase price of the security as quoted on a national exchange
1244 or other market on which the property is regularly traded at the
1245 time the securities or other ownership interest is remitted to
1246 the claimant or the claimant's representative. Fees and costs
1247 for tangible property or safe-deposit box accounts shall be
1248 based on the value of the tangible property or contents of the

1249 safe-deposit box at the time the ownership interest is
1250 transferred or remitted to the claimant. Total fees and costs on
1251 any single account owned by a natural person residing in this
1252 country must not exceed $1,000; or
1253 (b) Fully disclose that the property is held by the
1254 Division ~~Bureau~~ of Unclaimed Property of the Department of
1255 Financial Services pursuant to this chapter, the mailing address
1256 of the division ~~bureau~~, the Internet address of the division
1257 ~~bureau~~, the person or name of the entity that held the property
1258 prior to the property becoming unclaimed, the date of the
1259 holder's last contact with the owner, if known, and the
1260 approximate value of the property, and identify which of the
1261 following categories of unclaimed property the claimant's
1262 representative is seeking to recover, as reported by the holder:
1263 1. Cash accounts.
1264 2. Stale dated checks.
1265 3. Life insurance or annuity contract assets.
1266 4. Utility deposits.
1267 5. Securities or other interests in business associations.
1268 6. Wages.
1269 7. Accounts receivable.
1270 8. Contents of safe-deposit boxes.
1271
1272 This subsection shall not apply if probate proceedings must be
1273 initiated on behalf of the claimant for an estate that has never
1274 been probated or if the unclaimed property is being claimed by a

1275 person outside of the United States.
1276 (3)(a) A power of attorney described in paragraph (2)(b)
1277 must state in 12-point type or greater in the order indicated
1278 with the blank spaces accurately completed:
1279
1280 FULL DISCLOSURE STATEMENT
1281
1282 The property is currently held by the State of Florida
1283 Department of Financial Services, Division ~~Bureau~~ of
1284 Unclaimed Property, pursuant to chapter 717, Florida
1285 Statutes. The mailing address of the Division ~~Bureau~~
1286 of Unclaimed Property is ..... The Internet
1287 address of the Division ~~Bureau~~ of Unclaimed Property
1288 is .....
1289
1290 The property was remitted by: .....
1291
1292 Date of last contact: .....
1293
1294 Property category: .....
1295
1296 Section 42. Subsection (2) of section 717.1351, Florida
1297 Statutes, is amended to read:
1298 717.1351 Acquisition of unclaimed property.—
1299 (2) All contracts to acquire ownership of or entitlement
1300 to unclaimed property from the person or persons entitled to the

1301 unclaimed property must be in 10-point type or greater and must:
1302 (a) Have a purchase price that discounts the value of the
1303 unclaimed property at the time the agreement is executed by the
1304 seller at no greater than 20 percent per account held by the
1305 department. An unclaimed property account must not be discounted
1306 in excess of $1,000. However, the $1,000 discount limitation
1307 does not apply if probate proceedings must be initiated on
1308 behalf of the seller for an estate that has never been probated
1309 or if the seller of the unclaimed property is not a natural
1310 person or is a person outside the United States; or
1311 (b) Fully disclose that the property is held by the
1312 Division ~~Bureau~~ of Unclaimed Property of the Department of
1313 Financial Services pursuant to this chapter, the mailing address
1314 of the division ~~bureau~~, the Internet address of the division
1315 ~~bureau~~, the person or name of the entity that held the property
1316 prior to the property becoming unclaimed, the date of the
1317 holder's last contact with the owner, if known, and the
1318 approximate value of the property, and identify which of the
1319 following categories of unclaimed property the buyer is seeking
1320 to purchase as reported by the holder:
1321 1. Cash accounts.
1322 2. Stale dated checks.
1323 3. Life insurance or annuity contract assets.
1324 4. Utility deposits.
1325 5. Securities or other interests in business associations.
1326 6. Wages.

1327 7. Accounts receivable.
1328 8. Contents of safe-deposit boxes.
1329
1330 The purchase agreement described in this paragraph must state in
1331 12-point type or greater in the order indicated with the blank
1332 spaces accurately completed:
1333
1334 FULL DISCLOSURE STATEMENT
1335
1336 The property is currently held by the State of Florida
1337 Department of Financial Services, Division ~~Bureau~~ of
1338 Unclaimed Property, pursuant to chapter 717, Florida
1339 Statutes. The mailing address of the Division ~~Bureau~~
1340 of Unclaimed Property is ..... The Internet
1341 address of the Division ~~Bureau~~ of Unclaimed Property
1342 is .....
1343
1344 The property was remitted by: .....
1345
1346 Date of last contact: .....
1347
1348 Property category: .....
1349
1350 Immediately above the signature line for the seller, the
1351 purchase agreement described in this paragraph must state in 12-
1352 point type or greater:

1353
1354 Seller agrees, by signing below, that the FULL
1355 DISCLOSURE STATEMENT has been read and fully
1356 understood.
1357 Section 43. Paragraphs (a) and (b) of subsection (5) of
1358 section 717.1400, Florida Statutes, are amended to read:
1359 717.1400 Registration.—
1360 (5) If a material change in the status of a registration
1361 occurs, a registrant must, within 30 days, provide the
1362 department with the updated documentation and information in
1363 writing. Material changes include, but are not limited to: a
1364 designated agent or employee ceasing to act on behalf of the
1365 designating person, a surrender, suspension, or revocation of a
1366 license, or a license renewal.
1367 (a) If a designated agent or employee ceases to act on
1368 behalf of the person who has designated the agent or employee to
1369 act on such person's behalf, the designating person must, within
1370 30 days, inform the Division ~~Bureau~~ of Unclaimed Property in
1371 writing of the termination of agency or employment.
1372 (b) If a registrant surrenders the registrant's license or
1373 the license is suspended or revoked, the registrant must, within
1374 30 days, inform the division ~~bureau~~ in writing of the surrender,
1375 suspension, or revocation.
1376 Section 44. Paragraphs (k) and (l) of subsection (6) of
1377 section 932.7055, Florida Statutes, are amended to read:
1378 932.7055 Disposition of liens and forfeited property.—

1379 (6) If the seizing agency is a state agency, all remaining
1380 proceeds shall be deposited into the General Revenue Fund.
1381 However, if the seizing agency is:
1382 (k) The Division of Investigative and Forensic Services
1383 ~~State Fire Marshal~~ in the Department of Financial Services, the
1384 proceeds accrued under the Florida Contraband Forfeiture Act
1385 shall be deposited into the Insurance Regulatory Trust Fund to
1386 be used for the purposes of arson suppression, arson
1387 investigation, and the funding of anti-arson rewards.
1388 (l) The Division of Investigative and Forensic Services
1389 ~~Insurance Fraud~~ of the Department of Financial Services, the
1390 proceeds accrued pursuant to ~~the provisions of~~ the Florida
1391 Contraband Forfeiture Act shall be deposited into the Insurance
1392 Regulatory Trust Fund as provided in s. 626.9893 or into the
1393 Department of Financial Services' Federal Law Enforcement Trust
1394 Fund as provided in s. 17.43, as applicable.
1395 Section 45. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1303 Life Insurance Coverage for Funeral Expenses
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1386

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Yaffe DY	Luczynski NJ

SUMMARY ANALYSIS

The PCS clarifies that the qualifications for licensure as a life agent require an individual not to be found by the Department of Financial Services (DFS) as untrustworthy or incompetent and that the individual also meet a series of enumerated qualifications.

The PCS raises the maximum amount of life insurance coverage that can be sold by a funeral director, a direct disposer, an employee of a funeral establishment, or a funeral establishment contracting with a life insurance agent, for a life insurance policy limited to funding a preneed contract. The coverage limit is raised from $12,500 to $21,000, 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.

The PCS renames a "certificate of authority" to a "preneed contract."

The PCS has an effective date of July 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

A preneed insurance policy, also referred to as a "preneed contract,"[1] covers the expense of a prearrangement for a funeral service and funeral merchandise. A "funeral service" generally consists of the ceremonies held to commemorate the life of the deceased.[2] "Funeral merchandise" is personal property offered or sold for use in the final disposition, such as caskets, urns, monuments, and register books.[3] To sell a preneed contract, an individual must have a valid preneed license.[4]

A preneed contract can be funded through a trust agreement or a life insurance policy. To sell a preneed contract funded through a trust agreement, an individual must be licensed as a preneed sales agent.[5] To sell a preneed contract funded by a life insurance policy, an individual must be licensed as a life agent.[6] Coverage is not limited to a specific dollar amount for a preneed contract funded by a trust agreement, but a preneed contract funded by a life insurance policy may not exceed $12,500 in coverage, plus an annual percentage increase based on the Annual Consumer Price Index for 2003.

Chapter 626, F.S., Part III, regulates life agents and licensure, including the licensure of agents authorized to sell life insurance policies as funding-vehicles for preneed contracts. To qualify for licensure as a life agent, an individual must not be found by the DFS to be untrustworthy or incompetent, or meet a series of enumerated qualifications.[7] A life agent is defined as an individual that represents an insurer as to life insurance contracts.[8] Funeral establishments[9] are authorized to contract with a life agent to sell life insurance policies limited to funding a preneed contract. Additionally, a funeral director, a director disposer, or an employee of a funeral establishment may be licensed to sell life insurance policies limited to funding a preneed contract if they hold a "certificate of authority" pursuant to s. 497.451, F.S.[10] These life insurance policies are limited to coverage not exceeding $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.

Effect of Proposed Changes

The PCS clarifies that the qualifications for licensure as a life agent require an individual not to be found by the DFS as untrustworthy or incompetent and that the individual also meet a series of enumerated qualifications.

The PCS raises the maximum amount of coverage that can be sold by a funeral director, a direct disposer, an employee of a funeral establishment, or a funeral establishment contracting with a life

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[1] A "'preneed contract' means any arrangement or method, of which the provider of funeral merchandise or services has actual knowledge, whereby any person agrees to furnish funeral merchandise or service in the future." s. 497.005(56), F.S.
[2] s. 497.005(33), F.S.
[3] s. 497.005(6), F.S.
[4] s. 497.452, F.S.
[5] The only exception to this requirement is individuals licensed as funeral directors may engage in preneed sales for the preneed licensee with whom they are affiliated without preneed sales agent licensure, pursuant to s. 497.466(1), F.S.
[6] s. 626.785, F.S.
[7] *Id.*
[8] s. 626.015(10), F.S.
[9] A "funeral establishment" is a facility licensed under ch. 497, F.S., where a funeral director or embalmer practices funeral directing or embalming. s. 497.005(35), F.S.
[10] A "certificate of authority" is a "preneed license."

insurance agent, for a life insurance policy limited to funding a preneed contract. The coverage limit is raised from $12,500 to $21,000, 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.[11] The changes are intended to provide the consumer with more flexibility when utilizing a life insurance-funded preneed contract and to accommodate for unforeseen needs and expenses that may arise as it relates to funeral expenses and merchandise.

The PCS renames a "certificate of authority" to a "preneed contract" in order to match its statutory counterpart, s. 497.452, F.S., which had previously made such change.

B. SECTION DIRECTORY:

Section 1: amends s. 626.785, F.S., relating to qualifications for licensure.

Section 2: provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues: None.

2. Expenditures: None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues: None.

2. Expenditures: None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The public will be able to purchase a larger limited life insurance policy to fund a preneed contract that covers the costs of funeral services.

D. FISCAL COMMENTS:

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

B. RULE-MAKING AUTHORITY:

None.

[11] Email from Lisa Coney, Compliance/Quality Assurance, Service Corporation International, RE: Florida Insurance & Banking Subcommittee -- House Bill 1303 Inquiry (Jan. 26, 2016).

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to life insurance agents; amending s.
3 626.785, F.S.; clarifying the qualifications to obtain
4 a license as a life agent; increasing the amount of
5 coverage allowed for certain life insurance policies
6 covering funeral expenses; providing an effective
7 date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Subsection (1) and subsection (3) of section
12 626.785, Florida Statutes, are amended to read:
13 626.785 Qualifications for license.—
14 (1) The department shall not grant or issue a license as
15 life agent to any individual found by it to be untrustworthy or
16 incompetent~~,~~. Additionally, each individual must also meet all
17 of the following qualifications: ~~or who does not meet the~~
18 ~~following qualifications:~~
19 (a) Must be a natural person of at least 18 years of age.
20 (b) Must be a United States citizen or legal alien who
21 possesses work authorization from the United States Bureau of
22 Citizenship and Immigration Services and a bona fide resident of
23 this state.
24 (c) Must not be an employee of the United States
25 Department of Veterans Affairs or state service office, as
26 referred to in s. 626.788.

27 (d) Must not be a funeral director or direct disposer, or
28 an employee or representative thereof, or have an office in, or
29 in connection with, a funeral establishment, except that a
30 funeral establishment may contract with a life insurance agent
31 to sell a preneed contract as defined in s. 497.005.
32 Notwithstanding other provisions of this chapter, such insurance
33 agent may sell limited policies of insurance covering the
34 expense of final disposition or burial of an insured in the
35 amount of $~~12,500~~21,000, plus an annual percentage increase
36 based on the Annual Consumer Price Index compiled by the United
37 States Department of Labor, beginning with the Annual Consumer
38 Price Index announced by the United States Department of Labor
39 for the year 20~~03~~16.
40 (e) Must take and pass any examination for license
41 required under s. 626.221.
42 (f) Must be qualified as to knowledge, experience, or
43 instruction in the business of insurance and meet the
44 requirements relative thereto provided in s. 626.7851.
45 (3) Notwithstanding any other provisions of this chapter,
46 a funeral director, a direct disposer, or an employee of a
47 funeral establishment that holds a ~~certificate of authority~~
48 preneed license pursuant to s. 497.452 may obtain an agent's
49 license to sell only policies of life insurance covering the
50 expense of a prearrangement for funeral services or merchandise
51 so as to provide funds at the time the services and merchandise
52 are needed. The face amount of insurance covered by any such

53 policy shall not exceed $~~12,500~~21,000, plus an annual percentage
54 increase based on the Annual Consumer Price Index compiled by
55 the United States Department of Labor, beginning with the Annual
56 Consumer Price Index announced by the United States Department
57 of Labor for 20~~03~~16.
58 Section 2. This act shall take effect July 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1383 Limited Purpose International Trust Company Representative Offices
SPONSOR(S): Insurance & Banking Subcommittee
TIED BILLS: HB 1385 **IDEN./SIM. BILLS:** SB 1106

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Insurance & Banking Subcommittee		Bauer	Luczynski

SUMMARY ANALYSIS

The Office of Financial Regulation (OFR)'s Division of Financial Institutions charters and regulates entities that engage in financial institution business in Florida, in accordance with the Florida Financial Institutions Codes (Codes), and ensures Florida-chartered financial institutions' compliance with state and federal requirements for safety and soundness. In addition, the OFR regulates international banking corporations that 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. An international banking corporation (IBC) may operate through a variety of business models, all of which must be licensed, and include international bank agencies, international representative offices, international trust company representative offices (ITCROs), international administrative offices, and international branches. If an IBC wants to maintain any of these offices in this state, the IBC is required to meet licensure requirements, ongoing safety and soundness requirements, and is subject to the examination and enforcement authority of the OFR including state and federal anti-money laundering and anti-terrorism laws.

Following the Allen Stanford Ponzi scheme, the OFR pursued legislation in 2010 to close a regulatory gap in the international banking statutes and to strengthen oversight of international banking entities operating in Florida. Specifically, the 2010 legislation requires licensure (through the IBC) of international trust company representative offices (ITCROs) which are organized and licensed under the laws of a foreign country, but are established or maintained in Florida for engaging in non-fiduciary activities. 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, such as advertising, marketing, communicating with customers, and providing customer account service information for the IBC.

According to industry representatives, the 2010 legislation created regulatory ambiguity for international trust companies and their Florida-based marketing offices like ITCROs, potentially subjecting them to the $20 million capital requirements for operating marketing and liaison offices in Florida. As a result, industry representatives have proposed a new limited purpose ITCRO (LPITCRO) regulatory framework. However, the OFR has numerous policy, regulatory, technical, and implementation concerns about the proposed LPITCRO regulatory framework.

The proposed committee substitute (PCS) represents a compromise proposal from industry representatives. The PCS creates a new section of ch. 663, F.S., to impose a moratorium on the OFR's enforcement of ch. 663, F.S., with respect to any ITCRO or any person who manages or controls or is employed by such ITCRO, if such person meets certain requirements and provides written assurances to the OFR. The moratorium does not affect the OFR's authority to otherwise enforce applicable provisions of the Codes or to prevent the unlawful conduct of banking or trust business in Florida, fraud, and violations of anti-money laundering and anti-terrorism laws. The PCS also directs the OFR to deliver a report to the Financial Services Commission, the Speaker of the House, and the President of the Senate by September 1, 2016, regarding state and federal ITCRO laws and to list jurisdictions raising supervisory concerns for the OFR.

The PCS has no impact on local governments, has an indeterminate impact on the private sector, and a negative impact on state expenditures. The OFR indicates that the report requirement will necessitate 8 FTEs since the OFR would have to review international trust laws of over 250 states, jurisdictions, and countries, and increased staff time to track the ITCRO entities seeking to qualify for the moratorium under the PCS.

The PCS is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

International Financial Services

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] Industry representatives 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 the Florida International Administrators Association (FIAA), 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). Industry advocates 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] FIAA seeks to create a limited purpose ITCRO (LPITCRO) regulatory framework that would be subject to registration; clarify that the administrative and compliance services do not involve discretionary investment, 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 services companies. The OFR's Division of Financial Institutions charters and regulates entities that engage in financial institution business in Florida, in accordance

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[1] Memorandum from McDonald Hopkins LLC, *International Trust Company Representative Offices,* (Mar. 8, 2015) , on file with Insurance & Banking Subcommittee staff.
[2] Id.
[3] Id.
[4] Id.

with the Florida Financial Institutions Codes (Codes) and the Florida Financial Institutions Rules,[5] and ensures Florida-chartered financial institutions' compliance with state and federal requirements for safety and soundness.

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 provisions of the 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" includes international bank agency, an international banking corporation, international branch, international representative office, international administrative office, and international trust company representative office.[14]

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 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

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[5] Chs. 655, 657, 658, 660, 663, 665, and 667, F.S.; ch. 69U-100 through 69U-150, F.A.C.

[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. See s. 663.01(6), F.S.

[7] ss. 663.04 and 663.05, F.S.

[8] s. 663.06(1), F.S.

[9] s. 663.061, F.S.

[10] s. 663.062, F.S.

[11] s. 663.0625, F.S.

[12] s. 663.063, F.S.

[13] s. 663.064, F.S.

[14] s. 655.005(i), F.S.

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:

- s. 655.031, F.S., relating to administrative enforcement guidelines;
- s. 655.032, F.S., relating to investigations, subpoenas, hearings, and witnesses;
- s. 655.0321, F.S., relating to hearings, proceedings, related documents, and restricted access;
- s. 655.033, F.S., relating to cease and desist orders;
- s. 655.037, F.S., relating to removal by the office of an officer, director, committee member, employee, or other person;
- s. 655.041, F.S., relating to administrative fines and enforcement; and
- s. 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 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 (ITCROs)

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

[15] s. 663.061, F.S.
[16] s. 663.064, F.S.
[17] s. 663.062, F.S.
[18] s. 663.063, F.S.
[19] s. 663.01(9), F.S.

- Such other activities as may be approved by the OFR or rules of the Financial Services Commission.[20]

Robert Allen Stanford & 2010 International Banking Legislation

In 2010, the Florida Legislature amended ch. 663, F.S., to establish the OFR's oversight responsibilities for "offshore" international non-depository trust companies that wish to establish an international trust company representative office (ITCRO) in Florida.[21] The legislation defined the ITCRO entity and established the licensing and regulatory requirements for these entities. The legislation was due, in part, to the exposure of the $7 billion dollar Ponzi scheme perpetrated by former Texas billionaire Robert Allen Stanford.

Since the late 1990s, 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 the 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. In late 1998, the Division of Banking of the Department of Banking and Finance (the OFR's predecessor agency) entered into a memorandum of understanding (MOU)[22] with the Stanford Trust Company Limited (Stanford Trust), an offshore trust company organized under the laws of Antigua and Barbuda. This MOU allowed the Stanford Trust to establish a trust representative office in Florida, and delineated permissible and impermissible activities.

The OFR, along with federal regulatory and law enforcement agencies, coordinated an investigation into the operations of Stanford Trust's Miami trust company representative offices. In 2009, Mr. Stanford was charged by the U.S. Securities and Exchange Commission for operating an $8 billion Ponzi scheme involving overvalued certificates of deposit (CD) issued by Stanford International Bank, LTD, located in Antigua. These CDs were marketed by representative offices in the U.S., some of which were located in Florida. The scheme is alleged to have involved over 30,000 clients in 136 countries on six continents. In 2012, Mr. Stanford was federally prosecuted and convicted of multiple counts of mail and wire fraud, obstruction, and conspiracy (including conspiracy to commit money laundering). He was sentenced to 110 years in prison for orchestrating a 20-year investment fraud scheme in which he misappropriated over $7 billion from Stanford International Bank. Only recently did federal authorities and the U.S. receiver reach a settlement agreement to expedite the distribution of assets back to victims of Stanford's Ponzi scheme.[23]

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 responsibility for the licensing and oversight of international banking

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[20] Section 663.0625, F.S.

[21] Ch. 2010-9, Laws of Fla.

[22] Florida Department of Banking and Finance and Stanford Trust Company Limited, Memorandum of Agreement (Dec. 1998), on file with Insurance & Banking Subcommittee staff.

[23] U.S. DEPARTMENT OF JUSTICE, *Pending Criminal Division Cases: U.S. v. Robert Allen Stanford et al.*, at http://www.justice.gov/criminal-vns/case/stanfordr (last visited Jan. 28, 2016).
Lucy Komisar, Michael Sallah, and Rob Barry, *Exclusive: Florida banking agency helped Stanford set up unregulated office to sell his phony CDs*, MIAMI HERALD (July 5, 2009), at A1.

corporations that may or may not have trust powers and wish to establish representative offices, administrative offices, branches, and agencies in Florida. By specifically providing for the licensure of representative offices of international non-depository trust companies, the OFR was better positioned to provide for regulatory oversight of offshore trust companies and related operations in Florida. To date, no ITCROs are licensed with the OFR, although 2 international administrative offices, 10 international bank agencies, 6 international representative offices, and 6 international bank branches are currently licensed with the OFR.[24]

According to industry representatives, the 2010 legislation created regulatory ambiguity for international 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] FIAA seeks 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"; therefore, they should be exempt from its licensure and capital requirements, but still subject to appropriate registration and supervision by the OFR. HB 1383, as filed, amends chs. 663 to create a new entity known as limited purpose international trust company representative office (LPITCROs).

According to the OFR, current law requires an offshore entity that proposes the establishment of an ITCRO to obtain a license under ch. 663, F.S. HB 1383 would require only the onshore LPITCRO to be registered with the OFR. As a result, the operations and controlling shareholders of the offshore non-depository trust company would be unknown while allowing key regulatory oversight parameters such as capital requirements to be minimized, exposing unascertainable risk to consumers doing business in Florida. 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 OFR has also expressed numerous policy, other regulatory, technical, and implementation concerns about the proposed LPITCRO regulatory framework.[26]

To date, the OFR and the FIAA have not reached a mutually agreeable regulatory framework for these entities. The PCS represents a compromise proposal from the FIAA.

Effect of the Proposed Committee Substitute (PCS)

The PCS creates a new section of ch. 663, F.S., to impose a moratorium on the OFR's enforcement of ch. 663, F.S., with respect to any ITCRO or any person who manages or controls or is employed by such ITCRO, if such person:

- Has been organized or qualified to do business in this state since October 1, 2013;
- Has not been the subject of any consumer complaint to the OFR;
- Has not been convicted of a felony or subject to any regulatory penalties within 5 years of the PCS's effective date;
- Does not provide banking or fiduciary trust services, promote or sell investments or accept custody of assets.

The moratorium does not affect the OFR's authority to otherwise enforce ch. 655, F.S., or ch. 663, F.S., or other applicable provisions of the Codes to prevent the unlawful conduct of banking or trust business in Florida, to prevent fraud and violations of anti-money laundering and anti-terrorism laws or to protect the public from imminent harm. The PCS provides that companies may qualify for this moratorium, by providing written assurances of the conditions above.

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[24] OFFICE OF FINANCIAL REGULATION, *Financial Institution Search*, at https://real.flofr.com/ConsumerServices/FinancialInstitutions/InstSrch.aspx (search conducted Jan. 28, 2016).
[25] Memorandum from McDonald Hopkins LLC (Mar. 8, 2015) , on file with Insurance & Banking Subcommittee staff.
[26] Office of Financial Regulation, 2016 Agency Analysis of House Bill 1383, pp. 12-22 (Jan. 19, 2016).

The PCS also directs the OFR to deliver a report to the Financial Services Commission, the Speaker of the House, and the President of the Senate by September 1, 2016, describing current state and federal laws regarding ITCROs, particularly permissible, restricted, or prohibited activities and licensure requirements. The report must also include a list of international trust jurisdictions that the OFR does not consider to provide adequate supervision and regulation of international trust companies or are "at risk" jurisdictions for money laundering or terrorist financing. The report must also provide authorities or sources that the OFR relied upon to prepare this list of international trust jurisdictions.

B. SECTION DIRECTORY:

Section 1. Creates s. 663.041, F.S., regarding a licensing moratorium, reporting requirements, and report.

Section 2. Provides the PCS takes effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The PCS requires the OFR to prepare a report and to review written submissions from the ITCRO industry. The OFR indicates that it is unable to absorb this additional workload. To comply, the OFR will need to hire an additional 8 FTEs to query and review the states, territories, jurisdictions, and countries in order to prepare and timely deliver the report to the House Speaker, Senate President, and Financial Services Commission by September 1, 2016. As there are over 250 states, territories, jurisdictions, and countries to query and review, additional FTEs may be needed to meet the September 1, 2016 deadline.

Additionally, the OFR notes that it has no database to track the ITCRO entity. In the short-term, the OFR would be able to track information related to these entities by utilizing a series of spreadsheets. However, reliance on such spreadsheets is less than ideal and, moreover, highlights the OFR's need for funding to bring the Division of Financial Institutions into the Regulatory Enforcement and Licensing System (REAL System), as submitted in the OFR's 2016-2017 Legislative Budget Requests.[27]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. The PCS provides a limited moratorium on ITCRO licensing requirements.

D. FISCAL COMMENTS:

[27] Office of Financial Regulation, Agency Analysis of 2016 Proposed Committee Substitute for House Bill 1383, pp. 5-6 (Jan. 29, 2016).

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None provided by the PCS.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Although the substance of the proposed committee substitute characterizes the newly created statute as a "moratorium," the OFR states that the PCS is effectively a permanent exemption that prevents the OFR's enforcement of provisions in ch. 663, F.S., relating to ITCROs. This would permit ITCROs to operate in Florida without proper oversight. The OFR maintains that, by enacting the 2010 legislation, 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.[28]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[28] *Id.* at 6.

1 A bill to be entitled
2 An act relating to international trust company
3 representative offices; creating s. 663.041, Florida
4 Statutes; providing a moratorium on licensing
5 requirements; providing exceptions; requiring written
6 submissions to be provided to the office; requiring a
7 study from the Office of Financial Regulation;
8 providing an effective date.
9
10 Be It Enacted by the Legislature of the State of Florida:
11
12 Section 1. Section 663.041, Florida Statutes, is created
13 to read:
14 (1) The office shall not enforce the provisions of chapter
15 663 with respect to any international trust company
16 representative office, or any person who manages or controls or
17 is employed by such international trust company representative
18 office, that:
19 (a) Has been organized or qualified to do business in this
20 state since October 1, 2013;
21 (b) Has not been the subject of any consumer complaint to
22 the office;
23 (c) Has not been convicted of a felony or ordered to pay a
24 fine or penalty in any proceeding initiated by any federal,
25 state, foreign or local law enforcement or regulatory agency
26 within 5 years of the effective date of this section; and

27 (d) Does not provide banking or fiduciary trust services,
28 promote or sell investments or accept custody of assets.
29 (2) This moratorium shall not prevent the office from
30 otherwise enforcing chs. 655, 663, or other applicable
31 provisions of the Financial Institutions Codes to prevent the
32 unlawful conduct of the banking or trust business in this state,
33 to prevent fraud or violations of anti-money laundering and
34 anti-terrorism laws or to protect the public from imminent harm.
35 (3) Any company that seeks to qualify for this moratorium
36 shall notify the office in writing by May 1, 2016, and shall
37 provide the following to the office:
38 (a) Written proof that it has been organized or qualified
39 to do business in this state since October 1, 2013;
40 (b) The name or names under which it conducts business in
41 this state, the address of its registered office and the
42 locations from which it conducts business;
43 (c) A declaration under penalty of perjury signed by its
44 executive officer that:
45 1. It has not been the subject of any consumer complaint
46 to the office; and
47 2. It not been convicted of a felony or ordered to pay a
48 fine or penalty in any proceeding initiated by any federal,
49 state, foreign or local law enforcement or regulatory agency
50 within 5 years of the effective date of this section; and
51 3. It does not provide banking or fiduciary trust
52 services, promote or sell investments or accept custody of

53 assets.
54 (4) The office is hereby directed to deliver by September
55 1, 2016, a report to the Financial Services Commission, the
56 Speaker of the House and the President of the Senate describing
57 existing legislation or regulations of the United States or of
58 any state or territory of the United States regarding
59 international trust company representative offices or any entity
60 providing marketing or client liaison services for foreign trust
61 companies. The office particularly will address what specific
62 activities are permitted, are restricted or are prohibited and
63 the specific requirements for any licensure. It will also note
64 the absence of any such legislation or regulation. In addition,
65 the office shall prepare a list of international trust
66 jurisdictions that it considers do not provide adequate
67 supervision and regulation of trust companies or are considered
68 "at risk" jurisdictions for money laundering or terrorist
69 financing, explaining the reasons for its conclusion. The office
70 shall provide together with its report the authorities or
71 sources on which it relied to develop such list.
72 Section 2. This act shall take effect upon becoming a law.

INSURANCE & BANKING SUBCOMMITTEE

PCS for HB 1383 by Rep. Moraitis
Limited Purpose International Trust Company Representative Offices

AMENDMENT SUMMARY
February 1, 2016

Amendment 1 by Rep. Moraitis (line 72): Provides that the bill is repealed on July 1, 2017.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	____	

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1 Committee/Subcommittee hearing bill: Insurance & Banking
2 Subcommittee
3 Representative Moraitis offered the following:
4
5 **Amendment 1 (with title amendment)**
6 Remove line 72 and insert:
7 Section 2. This act shall take effect upon becoming a law,
8 and shall be repealed on July 1, 2017.
9
10 ----------
11 **T I T L E A M E N D M E N T**
12 Remove line 8 and insert:
13 providing an effective date and a repeal date.