Tab 1	**SB 924** by **Brandes**; Civil Actions Against Insurers

Tab 2	**SB 1306** by **Thurston**; (Similar to H 00811) Individual Retirement Accounts

Tab 3	**SB 1338** by **Wright (CO-INTRODUCERS) Harrell**; Prescription Drug Coverage

~~632656~~	A	S	WD	BI, Lee	Before L.44:	01/28 06:08 PM
275668	A	S	RCS	BI, Wright	Delete L.146 - 148:	01/28 06:08 PM
~~422030~~	A	S	WD	BI, Thurston	btw L.510 - 511:	01/28 06:08 PM

Tab 4	**SB 1564** by **Stargel**; (Identical to H 01189) Genetic Information for Insurance Purposes

208866	D	S	RCS	BI, Stargel	Delete everything after	01/28 06:08 PM

Tab 5	**SB 1672** by **Broxson**; (Similar to CS/H 00813) Protection of Vulnerable Investors

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Tuesday, January 28, 2020
TIME: 4:00—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Broxson, Chair; Senator Rouson, Vice Chair; Senators Brandes, Gruters, Lee, Perry, Taddeo, and Thurston

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 924** Brandes	Civil Actions Against Insurers; Providing that, in third-party bad faith actions against insurers, insureds and claimants have the burden to prove that an insurer acted in reckless disregard for insured rights which resulted in damage to the insured or the claimant; providing that insured or claimant actions or inactions are relevant in bad faith actions; providing that an insurer is not liable if certain conditions are met; providing that an insurer is not liable beyond available policy limits as to certain competing third-party claims if it files an interpleader action within a certain timeframe, etc. BI 01/28/2020 Temporarily Postponed JU RC	Temporarily Postponed
2	**SB 1306** Thurston (Similar H 811)	Individual Retirement Accounts; Specifying that interests in certain individual retirement funds or accounts which are exempt from creditor claims continue to be exempt after certain transfers incident to divorce, etc. BI 01/28/2020 Favorable JU RC	Favorable Yeas 6 Nays 0
3	**SB 1338** Wright	Prescription Drug Coverage; Authorizing the Office of Insurance Regulation to examine pharmacy benefit managers; requiring health insurers and health maintenance organizations, or pharmacy benefit managers on behalf of health insurers and health maintenance organizations, to annually report specified information to the office; specifying requirements relating to brand-name and generic drugs in contracts between pharmacy benefit managers and pharmacies or pharmacy services administration organizations, etc. BI 01/21/2020 Not Considered BI 01/28/2020 Fav/CS AHS AP	Fav/CS Yeas 6 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1564** Stargel (Identical H 1189)	Genetic Information for Insurance Purposes; Prohibiting life insurers and long-term care insurers from canceling, limiting, or denying coverage, or establishing differentials in premium rates, based on genetic information under certain circumstances; prohibiting such insurers from taking certain actions relating to genetic information for any insurance purpose, etc. BI 01/28/2020 Fav/CS JU RC	Fav/CS Yeas 5 Nays 1
5	**SB 1672** Broxson (Similar CS/H 813)	Protection of Vulnerable Investors; Requiring securities dealers, investment advisers, and associated persons to immediately report knowledge or suspicion of abuse, neglect, or exploitation of vulnerable adults to the Department of Children and Families' central abuse hotline; authorizing dealers and investment advisers to delay disbursements or transactions of funds or securities from certain accounts associated with specified adults if certain conditions are met; providing for administrative and civil immunity for dealers, investment advisers, and associated persons, etc. BI 01/28/2020 Favorable JU RC	Favorable Yeas 6 Nays 0
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 924
INTRODUCER:	Senator Brandes
SUBJECT:	Civil Actions Against Insurers
DATE:	January 27, 2020 REVISED:

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

I. Summary:

SB 924 amends the civil remedies statute of the Insurance Code specific to third-party bad faith causes of action. The bill provides the insured or claimant has the burden of proving the insurer acted in bad faith through reckless disregard for the insured's rights and that this reckless disregard caused damaged to the insured or claimant. The bill codifies legal precedent that the conduct of the insurer or claimant is relevant to the trier of fact. The bill creates an affirmative defense where the conduct of the insured or claimant causes an excess judgment. The bill requires the insurer to advise the insured of settlement opportunities, probable outcome of litigation, and possibility of an excess judgment with steps to avoid such judgment. The bill precludes a third-party bad faith determination against the insurer if the insurer was ready and willing to settle for policy limits within 45 days of receiving the notice of loss. Finally, the bill precludes liability beyond policy limits in an interpleader case of two or more third-party claimants to a single claim if the insurer brings the interpleader action within 90 days of receiving notice of the competing claims.

The bill takes effect July 1, 2020.

II. Present Situation:

Common Law and Statutory Bad Faith

Bad faith law was designed to protect insureds who have paid their premiums and who have fulfilled their contractual obligations by cooperating fully with their insurer in the resolution of claims. Bad faith jurisprudence holds insurers accountable for failing to fulfill their obligations.[1] There are two distinct but very similar types of bad faith causes of action that may be initiated against an insurer: first-party and third-party.

[1] *Harvey v. GEICO General Insurance Company*, 251 So.3d 1, 6, (Fla. 2018)(quoting *Berges v. Infinity Insurance Company*, 896 So.2d 665 at 682).

Florida courts have recognized common law third-party bad faith causes of action since 1938.[2] A third-party bad faith cause of action arises when an insurer fails in good faith to settle a third party's claim against the insured within policy limits and exposes the insured to liability in excess of his or her insurance coverage.[3] Third-party bad faith causes of actions arose in response to the argument that there was a practice in the insurance industry of rejecting without sufficient investigation or consideration claims presented by third parties against an insured, thereby exposing the insured individual to judgments exceeding the coverage limits of the policy while the insurer remained protected by a policy limit.[4] With no actionable remedy, insureds in this state and elsewhere were left personally responsible for the excess judgment amount.[5] Florida courts recognized common law third-party bad faith causes of action in part because the insurers had the power and authority to litigate or settle any claim, and thus owed the insured a corresponding duty of good faith and fair dealing in handling these third-party claims.[6]

In contrast to common law third-party bad faith causes of action, Florida courts do not recognize a common law first-party bad faith cause of action by the insured against its own insurer.[7] If an insurer acts in bad faith in settling a claim filed by its insured, the only common law remedy available to the insured is a breach of contract action against its own insurer with recoverable damages limited to those contemplated by the parties to the policy.[8]

The 1982 Legislature's enactment of s. 624.155, F.S., created a statutory first-party bad faith cause of action,[9] codified Florida Supreme Court precedent authorizing a common-law third-party bad faith cause of action,[10] and eliminated the distinction between statutory first- and third-party bad faith causes of action.[11]

Section 624.155, F.S., provides that any party may bring a bad faith action against an insurer, and defines bad faith on the part of the insurer as:

- Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured with due regard for her or his interests;
- Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or
- Except as to liability coverages, failing to promptly settle claims, when the obligation to settle the claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.[12]

---

[2] *Auto Mut. Indem. Co. v. Shaw*, 184, So. 852 (Fla. 1938).
[3] *Opperman v. Nationwide Mutual Fire Insurance Company*, 515 So.2d 263, 265 (Fla. 5th DCA 1987).
[4] *Allstate Indem. Co. v. Ruiz*, 899 So.2d 1121, 1125 (Fla. 2005).
[5] *Id*.
[6] *Id*.
[7] *State Farm Mut. Auto. Ins. Co. v. Laforet*, 658 So.2d 55, 58-59 (Fla. 1995).
[8] *Talat Enterprises, Inc. v. Aetna Cas. and Sur. Co.*, 753 So.2d 1278, 1281 (Fla. 2000).
[9] Chapter 82-243, s. 9, L.O.F.
[10] *Macola v. Government Employees Ins. Co.*, 953 So.2d 451, 456 (Fla. 2006). *See also State Farm Fire & Cas. Co. v. Zebrowski*, 706 So.2d 275, 277 (Fla. 1997).
[11] *Id*.
[12] Section 624.155(1)(b)(1)-(3), F.S.

Civil Remedy Notice

As a condition precedent to bringing a bad faith action under s. 624.155, F.S., the insured must have provided the insurer and the Department of Financial Services at least 60 days written notice of the alleged violation.[13] The notice must specify the following information:

- The statutory provision, including the specific language of the statute, which the authorized insurer allegedly violated;
- The facts and circumstance giving rise to the violation;
- The name of any individual involved in the violation;
- A reference to specific policy language that is relevant to the violation, if any. If the person bringing the civil action is a third-party claimant, she or he shall not be required to reference the specific policy language if the authorized insurer has not provided a copy of the policy to the third party claimant pursuant to written request; and
- A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized under s. 624.155, F.S.[14]

The 60-day window contemplated under s. 624.155, F.S., provides insurers with a final opportunity to comply with their claim-handling obligations when a good-faith decision by the insurer would indicate that contractual benefits are owed.[15] If the insurer in turn fails to respond to a civil remedy notice within the 60-day window, there is presumption of bad faith sufficient to shift the burden to the insurer to show why it did not respond.[16]

In *Talat Enterprises, Inc. v. Aetna Cas. and Sur. Co.,* the Florida Supreme Court addressed the question of whether an insurer that paid all contractual damages within the 60-day window, but none of the extra-contractual damages, satisfied the requirement for payment of damages under s. 624.155(3)(c), F.S., thereby precluding the claimant's bad faith action. The Florida Supreme Court answered in the affirmative, explaining:

> Section 624.155 does not impose on an insurer the obligation to pay whatever the insured demands. The 60-day window is designed to be a cure period that will encourage payment of the underlying claim, and avoid unnecessary bad faith litigation. Surely an insurer need not immediately pay 100percent of the damages claimed to flow from bad faith conduct in order to avoid the chance that the insured will succeed on a bad faith cause of action. If the insurer may avoid a bad faith action only by paying in advance every penny of the damages that it faces if it loses at trial, the insurer would have no reason to pay.[17]

[13] Section 624.155(3), F.S.
[14] Section 624.155(3)(b)(1)-(5), F.S.
[15] *See Talat Enterprises, Inc.*, 753 So.2d at 1284.
[16] *Fridman v. Safeco Ins. Co. of Illinois*, 185 So.3d 1214, 1220, (Fla. 2016); *Imhof v. Nationwide Mut. Ins. Co.*, 643 So.2d 617, 619 (Fla 1994).
[17] *See Talat Enterprises, Inc.*, 753 So.2d at 1282. (quoting *Talat Enterprises, Inc. v. Aetna Cas. & Sur. Co.*, 952 F.Supp. 773, 778 (M.D.Fla.1996)).

Legal Standard of Proof

Each case is determined on its own facts and ordinarily the question of failure to act in good faith with due regard for the interests of the insured is for the jury.[18] In Florida, the question of whether an insurer has acted in bad faith in handling claims against the insured is determined under a "totality of the circumstances" standard.[19] In *Harvey v. Geico General Insurance Company*, the Florida Supreme Court explained that the critical inquiry in a bad faith case is whether "the insurer diligently, and with the same haste and precision as if it were in the insured's shoes, worked on the insured's behalf to avoid an excess judgment."[20] The claimant bringing the bad faith action has the burden of proving the insurer acted in bad faith by a preponderance of the evidence.[21]

Offer of Settlement

Under Florida law, an insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so.[22] In considering whether the insurer has given fair consideration to a settlement offer that is not unreasonable under the facts, Florida courts look to whether there was a realistic opportunity for settlement.[23]

Duty to Advise Insured of Settlement Opportunities

Florida courts have interpreted the duty of good faith insurers owe to insureds in handling their claims to include the duty to advise the insured of settlement opportunities. In *Harvey v. Geico General Insurance Company*, the Florida Supreme Court reaffirmed its 1980 decision in *Boston Old Colony Ins. v. Gutierrez* recognizing the insurer's duty to advise the insured of settlement opportunities:

> This good faith duty obligates the insurer to advise the insured of settlement opportunities, to advise as to the probable outcome of the litigation, to warn of the possibility of an excess judgment, and to advise the insured of any steps he might take to avoid same. The insurer must investigate the facts, give fair consideration to a settlement offer that is not unreasonable under the facts, and settle, if possible, where a reasonably prudent person, faced with the prospect of paying the total recovery, would do so. Because the duty of good faith involves diligence and care in the investigation and evaluation of the claim against the insured, negligence is relevant to the question of good faith.[24]

Conduct of the Claimant in the Settlement Context

Florida courts place the focus in a bad faith case on the conduct of the insurer.[25] However, Florida courts do not completely ignore the conduct of the claimant. In *Barry v. GEICO General*

[18] *Boston Old Colony Insurance Company v. Gutierrez*, 386 So.2d 783, 785 (Fla. 1980).
[19] *Berges v. Infinity Insurance Company*, 896 So.2d 665, 680 (Fla. 2005).
[20] See *Harvey*, 259 So.3d at 7.
[21] Cadle v. GEICO General Insurance Company, 838 F.3d 1113, 1119 (11th Cir. 2016).
[22] *Boston Old Colony Insurance Company v. Gutierrez*, 386 So.2d 783, 785 (Fla. 1980).
[23] *Barry v. GEICO General Insurance Company*, 938 So.2d 613, 618 (Fla. 4th DCA 2006).
[24] See *Harvey*, 259 So.3d at 6-7 (quoting *Boston Old Colony Insurance Company*, 386 So.2d at 785).
[25] *Id.*

Ins. Co., the 4th District Court of Appeals of Florida addressed the question of whether the trial court abused its discretion in shifting the focus to the motives of the claimant in a bad faith case where the claimant refused the insurer's settlement offer. The appeals court denied the trial court abused its discretion, explaining:

> Although Barry is correct that the focus of an insurance bad faith case is not on the motive of the claimant but of the insurer in fulfilling its duty to its insured, that does not mean that all inquiries into prior conduct and motives are irrelevant and prejudicial. In a bad faith case, the insurer has the burden to show that there was no realistic possibility of settlement within the policy limits. This question is decided based upon the totality of the circumstances. The conduct of Capelli and her attorney would be relevant to the question of whether there was any realistic possibility of settlement. Despite Capelli's testimony at trial that she would have settled the case if GEICO had not made the mistake, her actions and those of her attorney suggested otherwise. The jury could have concluded that the failure of her attorney to notify GEICO of his representation coupled with her refusal to meet with Stone on the settlement, among other incidents, showed that she did not want to settle with GEICO for the policy limits. Thus, GEICO did not inject irrelevant information into the case, and therefore we reject Barry's argument as to the cumulative nature of the errors.[26]

Interpleader Actions

Interpleader is an equitable remedy by which a court determines the rightful claimant of two or more claimants making the same claim against a third party.[27] Interpleader serves the purpose of allowing the defendant to avoid multiple litigations and multiple liability stemming from the same claim.[28] It is not intended to prevent multiple recoveries under the claim.[29] In the insurance context, insurers use interpleaders if claims are made by different parties.[30] For example, when a life insurer is presented with two or more competing life insurance claims, the insurer deposits the life insurance proceeds under the policy with the court until the court decides the rightful beneficiary.

Under common law, Florida courts recognize four requirements to maintain an interpleader action:

- The claims to the stake were dependent or had common origin;
- The same thing, debt, or stake was claimed by the defendants;
- The plaintiff had "no interest in the subject matter—that is, in strict interpleader as distinguished from a suit in the nature of interpleader"; and
- The plaintiff was appearing that "no act on his part … caused the embarrassment of conflicting claims and the peril of double vexation."[31]

---

[26] *Id*.
[27] Barron's Dictionary of Insurance Terms, 267 (6th ed. 2013)
[28] *Paul v. Harold Davis, Inc.*, 20 So.2d 795, 796 (1945).
[29] *Id*.
[30] *See supra* at Note 30.
[31] *Red Beryl, Inc. v. Sarasota Vault Depository, Inc.*, 176 So.3d 375, 383 (Fla. 2nd DCA 2015); *Riverside Bank of Jacksonville v. Fla. Dealers & Growers Bank*, 151 So.2d 834, 836 (Fla. 1st DCA 1963).

In contrast to common law, the Florida Rules of Civil Procedure provides that the only requirement to maintain an interpleader action is whether the stakeholder is or may be exposed to double or multiple liability for competing claims to a single fund.[32]

Rule 1.240, as adopted by the Florida Supreme Court, provides in pertinent part:

> Persons having claims against the plaintiff may be joined as defendants and required to interplead when their claims are such that the plaintiff is or may be exposed to double or multiple liability. It is not grounds for objection to the joinder that the claim of the several claimants or the titles on which their claims depend do not have common origin or are not identical but are adverse to and independent of one another, or that the plaintiff avers that the plaintiff is not liable in whole or in part to any or all of the claimants.[33]

Reckless Disregard Standard Under s. 624.155, F.S.

Section 624.155, F.S., prohibits the award of punitive damages under the section unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and these acts are:

- Willful, wanton, and malicious;
- In reckless disregard for the rights of any insured; or
- In reckless disregard for the rights of a beneficiary under a life insurance contract.

Section 624.155, F.S., does not define "reckless disregard." In the absence of a statutory definition supplied by the Legislature, the courts follow the common law definition.[34]

In *Farmer v. Brennan*, the Supreme Court of the United States (SCOTUS) recognized the common law definition of "recklessness" in the civil liability sphere to mean conduct or actions that objectively entail "an unjustifiably high risk of harm that is either known or so obvious that it should be known."[35]

SCOTUS in *Safeco Ins. Co. of America v. Burr* similarly recognized and applied the common law of "reckless disregard," citing to the Restatement (Second) of Torts at s. 500:

> The actor's conduct is in reckless disregard of the safety of another if he does an act or intentionally fails to do an act which it is his duty to the other to do, knowing or having reason to know of facts which would lead a reasonable man to realize, not only that his conduct creates an unreasonable risk of physical harm to another, but also that such risk is substantially greater than that which is necessary to make his conduct negligent.[36]

Florida courts, in turn, have distinguished between the "reckless disregard" and "willful, wanton, and malicious" standards under s. 624.155, F.S. For example, the Florida 4th District Court of Appeals in *Howell-Demarest v. State Farm Mut. Auto. Ins. Co*. noted that in the context of punitive damages under s. 624.155, F.S., the "reckless disregard" standard appears to be less stringent than the "willful, wanton, and malicious" standard that is necessary to support a

[32] Fla. R. Civ. P. 1.240.
[33] *Id*.
[34] *Morissette v. US*, 342 U.S. 246, 263 (1952).
[35] *Farmer v. Brennan*, 511 U.S. 825, 836 (1994).
[36] *Safeco Ins. Co. of America v. Burr*, 551 U.S. 47, 69 (2007).

punitive damage award in general and equivalent to the criminal standard as applied to manslaughter.[37] However, the same court in *Home Ins. Co. v. Owens*, previously noted that the "culpable negligence" standard for manslaughter is defined as "reckless indifference to the rights of others," observed:

> As a consequence, any supposed variation between [the willful, wanton, and malicious standard] and the [reckless disregard standard] becomes somewhat amorphous and perhaps even circular.[38]

III. Effect of Proposed Changes:

Section 1 amends s. 624.155, F.S., to provide an insured or claimant bringing either a statutory or common law third-party bad faith action has the burden to prove the insurer acted in bad faith. The claimant must prove the insurer acted in reckless disregard for the rights of the insured and that the insurer's reckless disregard caused damaged to the insured or claimant.

The bill provides that the conduct of the insured or claimant is relevant for the trier of fact to consider when deciding a third-party bad faith claim. The bill creates an affirmative defense to a third-party bad faith claim where the conduct of the insured or claimant, in whole or in part, caused an excess judgment.

The bill requires the insurer to advise the insured of settlement opportunities, the probable outcome of litigation, the possibility of an excess judgment, the steps to avoid an excess judgment, and defend the insured against an action when the complaint alleged facts that fairly and potentially bring the action within policy coverage. The bill precludes the insurer from a determination of third-party bad faith if the insurer satisfied this paragraph's requirements and stood ready and willing to settle for the policy limits within 45 days of receiving written notice of the loss.

The bill further provides the insurer is not liable beyond the policy limits if the insurer brings an interpleader action against two or more third-party claimants to a single claim within 90 days of receiving notice of the competing claims. The bill provides that competing third-party claims are entitled to a prorated share of the policy limits, determined by the trier of fact.

Section 2 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[37] *Howell-Demarest v. State Farm Mut. Auto. Ins. Co.*, 673 So.2d 526, 528-529 (Fla. 4th DCA 1996).
[38] *Home Ins. Co. v. Owens*, 573 So.2d 343, 346 (Fla. 4th DCA 1990).

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 624.155 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Brandes

24-00450C-20 2020924__

A bill to be entitled

An act relating to civil actions against insurers; amending s. 624.155, F.S.; providing that, in third-party bad faith actions against insurers, insureds and claimants have the burden to prove that an insurer acted in reckless disregard for insured rights which resulted in damage to the insured or the claimant; providing that insured or claimant actions or inactions are relevant in bad faith actions; specifying an affirmative defense; specifying an insurer's duties to insureds; providing that an insurer is not liable if certain conditions are met; providing that an insurer is not liable beyond available policy limits as to certain competing third-party claims if it files an interpleader action within a certain timeframe; providing construction; providing an effective date.

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

Section 1. Subsection (1) of section 624.155, Florida Statutes, is amended, and subsections (10) and (11) are added to that section, to read:

624.155 Civil remedy.—

(1) Any person may bring a civil action against an insurer when such person is damaged:

(a) By a violation of any of the following provisions by the insurer:

1. Section 626.9541(1)(i), (o), or (x);

24-00450C-20 2020924__

2. Section 626.9551;

3. Section 626.9705;

4. Section 626.9706;

5. Section 626.9707; or

6. Section 627.7283.

(b) By the commission of any of the following acts by the insurer:

1. Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests;

2. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

3. Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a claim has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

Notwithstanding paragraphs (a) and (b) ~~the provisions of the above to the contrary~~, a person pursuing a remedy under this section need not prove that such act was committed or performed with such frequency as to indicate a general business practice.

(10) Notwithstanding subsections (1)-(9), in an action for third-party bad faith under this chapter or at common law:

(a) An insured or a claimant has the burden to prove that the insurer acted in bad faith. An insured or a claimant must prove that the insurer acted in reckless disregard for the

rights of any insured and that the reckless disregard caused damage to the insured or claimant.

(b) The actions or inactions of the insured or claimant are relevant in an action for bad faith. It is an affirmative defense to a claim for bad faith that the insured's or claimant's own conduct, in whole or in part, caused an excess judgment.

(c) An insurer must advise an insured of settlement opportunities, advise an insured as to the probable outcome of the litigation, warn an insured of the possibility of an excess judgment, advise an insured of steps to avoid an excess judgment, and defend an insured against a legal action when the complaint alleges facts that fairly and potentially bring the suit within policy coverage. An insurer is not liable if the insurer fulfills such obligations and the trier of fact finds that, within 45 days after receipt of the written notice of loss, the insurer stood ready and willing to settle for policy limits.

(11) If two or more third-party claimants in a liability claim make competing claims arising out of a single occurrence which in total exceed the available policy limits of one or more of the insured parties who may be liable to the third-party claimants, an insurer is not liable beyond the available policy limits for failure to pay all or any portion of the available policy limits to one or more of the third-party claimants if, within 90 days after receiving notice of the competing claims in excess of the available policy limits, the insurer files an interpleader action under the Florida Rules of Civil Procedure. The competing third-party claimants are entitled to a prorated

share of the policy limits as determined by the trier of fact. An insurer's interpleader action does not alter or amend the insurer's obligation to defend its insured.

Section 2. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28
Meeting Date

SB 924
Bill Number (if applicable)

Topic Civil Actions

Amendment Barcode (if applicable)

Name Greg Black

Job Title Lobbyist

Address 1727 Highland Plaza
Street

Phone 509 8022

TLH
City

FL
State

32308
Zip

Email gry@waypointstrat.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing R Street Institute

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

01.28.20
Meeting Date

924
Bill Number (if applicable)

Topic Civil Actions Against Insurers

Amendment Barcode (if applicable)

Name Kathy Maus

Job Title

Address 3600 Maclay Boulevard - Suite 101
Street

Phone (850) 894-4111

Tallahassee FL 32312
City *State* *Zip*

Email kmaus@butler.legal

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Justice Reform Institute

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/20
Meeting Date

SB 924
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Civil Actions Against Insurers

Name Beth A. Vecchioli

Job Title Sr. Director Gov't Consulting

Address 215 S. Monroe St., Ste. 500
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone 850-425-3393

Email bvecchioli@carltonfields.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing National Association of Mutual Insurance Companies

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/20
Meeting Date

924
Bill Number (if applicable)

Topic Civil Actions Against Insurers

Amendment Barcode (if applicable)

Name Carolyn Johnson

Job Title Policy Director

Address 136 S Bronough St
Street

Phone 521-1200

Tallahassee FL
City *State* *Zip*

Email cjohnson@flchamber.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Chamber of Commerce

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/20
Meeting Date

SB 924
Bill Number (if applicable)

Topic INSURANCE BAD FAITH

Amendment Barcode (if applicable)

Name FRED CUNNINGHAM

Job Title ATTORNEY

Address 2401 PGA BLVD, STE 140
Street

Phone 561 676 3333

PALM BEACH GDNS FL 33410
City *State* *Zip*

Email fred@dcwlaw.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing FJA

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Jan 28, 2020
Meeting Date

924
Bill Number (if applicable)

Topic Insurance Bad Faith

Amendment Barcode (if applicable)

Name Dale Swope

Job Title atty

Address 1234 6th Ave. E. Phone 813-477-4000
Street

Bradenton FL 34208 Email dales@judgelaw.com
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Taxpayers against Insurance Bad Faith, Inc.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1306
INTRODUCER:	Senator Thurston
SUBJECT:	Individual Retirement Accounts
DATE:	January 27, 2020
REVISED:	

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

I. Summary:

SB 1306 clarifies that any interest in an individual retirement account (IRA) or individual retirement annuity received during a transfer incident to divorce remains exempt from creditor claims after the transfer is complete.

Since the bill clarifies, but does not modify, existing law or practice, the bill is remedial in nature, and applies retroactively to all transfers made incident to divorce.

The bill is effective upon becoming a law.

II. Present Situation:

Asset Protections Available in Florida

Both the State Constitution and Florida Statutes contain exemptions to protect certain real and personal property of natural persons from forced sale by creditors. State constitutional exemptions, such as those for homestead property,[1] may only be modified through a constitutional amendment and a vote of the electorate; those contained in Florida Statutes may be modified by the Legislature. Chapter 222, F.S., outlines types of property statutorily exempted or immune from the claims of creditors.

Section 222.21, F.S., provides that pension money and certain tax-exempt funds or accounts are exempt from legal processes, such as forced sale. Subsection (1) protects certain money received by any debtor as a pensioner of the United States. Subsection (2) protects any money or other

[1] *See* Art. X, s. 4, Fla. Const.

assets payable to an owner, a participant, or a beneficiary from, and any interest[2] therein of any owner, beneficiary, or participant if the fund or account meets certain qualifications. Such funds or accounts are commonly known as qualified, tax-exempt retirement accounts, and must be either:

- Maintained in accordance with a master plan, volume submitter plan, prototype plan, any other plan, or other governing instrument preapproved by the Internal Revenue Service (IRS) as exempt from taxation under certain sections of the Internal Revenue Code of 1986 (IRC), as amended, regarding qualified retirement plans,[3] unless such exemption was overturned in a final and nonappealable proceeding;
- Maintained in accordance with a plan or governing instrument determined by the IRS to be exempt from taxation under certain sections of the IRC regarding qualified retirement plans,[4] unless such exemption was overturned in a final and nonappealable proceeding; or
- Not maintained in accordance with one of the above-described plans or governing instruments, if the person claiming the exemption proves by a preponderance of the evidence that the fund or account is maintained in substantial compliance with the applicable sections regarding tax-exempt retirement accounts, or would have been in substantial compliance with the applicable requirements for exemption under those sections, but for the negligent or wrongful conduct of another person.

The fund or account need not be maintained in accordance with a plan or governing instrument covered by any part of the Employee Retirement Income Security Act (ERISA) to be exempt.[5] Such funds or accounts are only protected to the extent they are not otherwise subject to claims of an alternate payee under a qualified domestic relations order, or claims of a surviving spouse pursuant to an order determining elective share and contribution in accordance with ch. 732, F.S.

Paragraph (2)(c) of s. 222.21, F.S., provides that the exemption for such money, other assets, or interest in these qualified, tax-exempt retirement accounts survives the owner's death upon a direct transfer or other eligible rollover excluded from gross income under the IRC, [6] such as, but not limited to, the direct transfer or eligible rollover to an inherited individual retirement account (IRA).[7] This allows a beneficiary to enjoy the exemption upon transfer. The Legislature expressly provided that this paragraph is intended to clarify existing law, be remedial in nature, and to apply retroactively to all inherited individual retirement accounts without regard to the date the account was created.

[2] Under Florida law, the word "interest," as used in statute providing exemption from creditors' claims for any interest of owner, beneficiary, or participant in enumerated tax-preferred funds or accounts, is a broad term encompassing many rights of a party, tangible, intangible, legal, and equitable. *In re Swarup*, 521 B.R. 328 (Bankr. M.D. Fla. 2014).
[3] 26 U.S.C. ss. 401(a) (stock bonus, pension, and profit sharing plans), 403(a) and 403(b) (annuity plans), 408 (individual retirement accounts (IRAs), 408A (Roth IRAs), 409 (tax credit employee stock ownership plans), 414 (provides definitions and special rules for certain plans, such as retirement plans for government and church employees), 457(b) (deferred compensation plans), or 501(a) (defining organizations exempt from taxation, including those defined in 401(a)).
[4] *Id*.
[5] Section 222.21(2)(b), F.S.
[6] Section 222.21(2)(c), F.S.
[7] *See* 26 U.S.C. s. 408(d)(3); pursuant to s. 222.21(2), F.S., individual retirement accounts, and interests therein, maintained in accordance with 26 U.S.C. s. 408 are exempted from legal processes, such as forced sale by creditors.

The specified tax-exempt retirement plans enumerated in subsection (2) are exempt from all legal proceedings, including bankruptcy, even though bankruptcy is a federal proceeding governed by the United States Bankruptcy Code (Bankruptcy Code).[8]

Transfer of s. 408 Retirement Accounts Incident to Divorce

Retirement accounts exempted from taxation by s. 408 of the IRC are exempted from legal processes, such as forced sale, by Florida law.[9] Section 408 of the IRC contemplates individual retirement accounts (IRAs) and individual retirement annuities.[10] An individual retirement account is a trust created or organized in the United States for the exclusive benefit of an individual, or his beneficiaries, of which the governing document meets certain requirements.[11] An individual retirement annuity is an annuity contract, or an endowment contract, issued by an insurance company which meets certain requirements.[12] An interest in an individual retirement account or individual retirement annuity may be transferred, but only upon the death or divorce of the original owner.[13] The transfer of an interest in an individual retirement account or individual retirement annuity incident to divorce is not a taxable event.[14] Effective upon such transfer, the interest in the individual retirement account or individual retirement annuity is treated as the account of the spouse.[15]

Exempted Property in Bankruptcy Proceedings

The Bankruptcy Code expressly recognizes exemptions provided under the state or local law of the domicile of the debtor.[16] Florida is an-opt out state, meaning that when a Florida resident files for bankruptcy, Florida law provides the exemptions available to the debtor, not the IRC.[17] Florida law contains a number of exemptions included in the IRC, such as IRAs and other pension, profit sharing, and retirement benefits.[18] Florida also exempts all inherited IRA accounts from creditor claims.[19] Likewise, the Bankruptcy Code exempts retirement funds in a fund or account exempt from taxation under most of the same sections of the IRC, such as those applicable to stock bonus, pension, and profit sharing plans, annuity plans, IRAs, and deferred compensation plans.[20]

Although there is no current controversy in Florida regarding the exemption for an IRA or an interest therein awarded incident to a divorce, a recent bankruptcy court decision in the United

[8] 11 U.S.C. s. 101, *et. seq.*; 11 U.S.C. s. 522(b)(3)(A).
[9] Section 222.21(2), F.S.
[10] 26 U.S.C. s. 408(a)-(c).
[11] *See* 26 U.S.C. s. 408(a), *et. seq.*
[12] 26 U.S.C. s. 408(c).
[13] 26 U.S.C. s. 408(d).
[14] 26 U.S.C. s. 408(d)(6).
[15] *Id*.
[16] 11 U.S.C. s. 522(b)(3)(A).
[17] Section 222.20, F.S.
[18] Section 222.21(2), F.S.
[19] Section 222.21(2)(c), F.S.
[20] 11 U.S.C. s. 522(d)(12) exempts "retirement funds to the extent that those funds are in a fund or account that is exempt from taxation under sections 401, 403, 408, 408A, 414, 457, or 501(a) of the Internal Revenue Code of 1986." Section 222.21(2), F.S., exempts qualified plans exempt from taxation under ss. 401(a), 403(a) and 403(b), specifically, 408, 408A, 414, 457(b), specifically, and 501(a) of the IRC. Unlike the Bankruptcy Code, Florida additionally exempts qualified tax credit employee stock ownership plans exempted from taxation under section 409 of the IRC.

States Bankruptcy Appellate Panel for the 8th Circuit may indicate a need to clarify Florida's exemption.

Two requirements must be satisfied in order for a debtor to claim funds as exempt retirement funds pursuant to the Bankruptcy Code:

- The amount must be retirement funds; and
- The retirement funds must be in an account that is exempt from taxation under one of the provisions of the IRC.[21]

The Bankruptcy Code does not define the term "retirement funds," so the term is applied within its ordinary meaning: sums of money set aside for the day an individual stops working.[22] In *In re Lerbakken*, 590 B.R. 895 (B.A.P. 8th Cir. 2018), the Court held that funds held in a 401K and IRA accounts awarded to a Chapter 7 debtor as part of a stipulated property settlement in a divorce proceeding were not "retirement funds" because while the debtor's former spouse had saved funds in those accounts for a joint retirement, any interest the debtor held in those accounts resulted from a property settlement.

III. Effect of Proposed Changes:

Section 1 amends paragraph (2)(c) of s. 222.21, F.S., to clarify that any interest in any IRA or individual retirement annuity received in a transfer incident to divorce as described in s. 408(d)(6)[23] of the Internal Revenue Code of 1986 (IRC), as amended, continues to be exempt after the transfer, regardless of the date the transfer was made.

To the extent s. 222.21(a), F.S., exempts a transferee's interest in an IRA or individual retirement annuity upon a transfer incident to divorce pursuant to s. 408(d)(6) of the IRC, the bill clarifies current law, which exempts such interests from the claims of the transferee's creditors.

Existing law provides that s. 222.21(2)(c), F.S., is intended to clarify existing law, is remedial in nature, and shall have retroactive application.

Section 2 provides that the act shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[21] 11 U.S.C. s. 522(d)(12).
[22] *Clark v. Rameker*, 573 U.S. 122, 127 (2014).
[23] Section 408(d)(6) of the IRC provides that a transfer of an interest in an individual retirement account or an individual retirement annuity to a spouse or former spouse under a divorce separation instrument is effective upon the time of the transfer, and is not a taxable event.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Retroactive Application

Once a bill becomes law, it is presumed to apply only prospectively. The presumption against retroactive application may be rebutted by clear evidence of legislative intent.[24] To determine if the terms of a statute and the purpose of the enactment indicate retroactive application, a court may consider the language, structure, purpose, and legislative history of the enactment.[25]

If the legislation clearly expresses an intent that the law apply retroactively, then the second inquiry is whether retroactive application is constitutionally permissible.[26] Even when the Legislature has clearly expressed its intention that the statute be given a retroactive application, courts must refuse to do so if it impairs vested rights, creates new obligations, imposes new penalties,[27] or impairs an obligation of contract.[28] For example, ex post facto legislation, i.e., a law that expands criminal liability retroactively by either creating a new crime for past conduct or by increasing the penalty for past conduct, is forbidden by both the Florida Constitution and the United States Constitution. Statutes that do not alter vested rights but relate only to remedies or procedure may be applied retroactively.[29]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

[24] *Florida Ins. Guar. Ass'n, Inc. v. Devon Neighborhood Ass'n, Inc*., 67 So. 3d 187 (Fla. 2011).
[25] *Id*.
[26] *Menendez v. Progressive Exp. Ins. Co., Inc*., 35 So. 3d 873 (Fla. 2010); *State Farm Mut. Auto. Ins. Co. v. Laforet*, 658 So. 2d 55 (Fla. 1995).
[27] *Id*.
[28] *Menendez v. Progressive Exp. Ins. Co., Inc*., 35 So. 3d 873 (Fla. 2010).
[29] *Metropolitan Dade County v. Chase Federal Housing Corporation*, 737 So. 2d 494 (Fla. 1999).

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends section 222.21 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Thurston

33-00658-20 20201306__

A bill to be entitled

An act relating to individual retirement accounts; amending s. 222.21, F.S.; specifying that interests in certain individual retirement funds or accounts which are exempt from creditor claims continue to be exempt after certain transfers incident to divorce; providing retroactive applicability; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 222.21, Florida Statutes, is amended to read:

222.21 Exemption of pension money and certain tax-exempt funds or accounts from legal processes.—

(2)

(c) Any money or other assets or any interest in any fund or account that is exempt from claims of creditors of the owner, beneficiary, or participant under paragraph (a) does not cease to be exempt after the owner's death by reason of a direct transfer or eligible rollover that is excluded from gross income under the Internal Revenue Code of 1986, including, but not limited to, a direct transfer or eligible rollover to an inherited individual retirement account as defined in s. 408(d)(3) of the Internal Revenue Code of 1986, as amended. Any interest in any fund or account received in a transfer incident to divorce as described in s. 408(d)(6) of the Internal Revenue Code of 1986, as amended, continues to be exempt after the transfer. This paragraph is intended to clarify existing law, is

33-00658-20 20201306__

remedial in nature, and shall have retroactive application to all inherited individual retirement accounts and to all such transfers incident to divorce without regard to the date an account was created or the date the transfer was made.

Section 2. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

APPEARANCE RECORD

1/28/2020 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB 1306

Meeting Date *Bill Number (if applicable)*

Topic Individual Retirement accounts *Amendment Barcode (if applicable)*

Name Sarah Butters

Job Title attorney / RPPTL Florida Bar

Address 315 S. Calhoun St. Phone 850-425-5447

Street

Tallahassee, FL 32301 Email SButters@ausley.com

City *State* *Zip*

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

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

Representing RPPTL - Florida Bar

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1338
INTRODUCER:	Banking and Insurance Committee and Senators Wright and Harrell
SUBJECT:	Prescription Drug Coverage
DATE:	January 29, 2020 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 1338 revises provisions of the Florida Insurance Code (code) relating to the transparency and oversight of pharmacy benefit managers (PBM) by the Office of Insurance Regulation (OIR). Many public and private employers and health plans contract with PBMs to administer their prescription drug benefits and to help control drug costs. The PBMs may negotiate drug prices with retail pharmacies and drug manufacturers on behalf of health plans or employers and, in addition to other administrative, clinical, and cost containment services, process drug claims for the plans or employers.

In recent years, the price of prescription drugs has gained attention at the state and federal level. Access to affordable prescription drugs is a significant issue for a number of consumers, particularly those without insurance; those prescribed expensive specialty drugs for treating serious or rare diseases; or those enrolled in private insurance with high cost-sharing requirements. The PBMs and drug manufacturers have come under scrutiny as policymakers have attempted to understand their role in the drug supply chain. Due to a lack of transparency in the marketplace, it is difficult to determine how much various payers and supply chain intermediaries pay for prescription drugs. Stakeholders have raised concerns regarding the regulatory oversight of the pharmacy benefit managers.

The bill provides the following changes to the code to increase oversight of PBMs and provide greater drug price transparency:

- Clarifies that the OIR has the authority to conduct market conduct examinations of PBMs to determine compliance with the provisions of the code.
- Requires insurers or HMOs, and their PBMs to comply with the pharmacy audit provisions, and provides authority for the OIR to enforce these provisions.
- Provides that a pharmacy may appeal audit findings, relating to the payment of a claim or the amount of a claim payment, through the Statewide Provider and Health Plan Claim dispute Resolution Program under the Agency for Health Care Administration.
- Clarifies that an insurer or HMO remains responsible for any violations of the pharmacy audit requirements and the prompt pay law by a PBM acting on its behalf.
- Clarifies the OIR's authority to review an insurer's contract with a PBM; authorizes OIR to review reasonableness of PBM fees; and allows the OIR to order the cancellation of such contracts under certain conditions. Currently, the OIR has the authority to review the reasonableness of fees within an HMO contract, and cancel such contracts if the fees are not reasonable.
- Revises the definition of the term, "maximum allowable cost;" and creates definitions of the terms, "brand drug," and "generic drug."
- Requires a PBM to pass through generic rebates to an insurer or HMO.
- Increases PBM transparency by requiring the submission of an annual report to the OIR regarding rebates and other information.

According to the PBM for the State Group Insurance program, the fiscal impact of the bill will result in an increase in plan cost of $8.82 million, which is $24.57 per member per year. There would be an increase in total members cost of $1.7 million.

II. Present Situation:

In 2019, private health insurance spending is expected to increase by 3.3 percent.[1] This trend is the net effect of faster spending growth in many services such as physician and clinical services and prescription drugs. In 2019, prescription drug spending growth is projected to increase by 4.6 percent, due to faster utilization growth from both existing and new drugs, as well as a modest increase in drug price growth. For the remainder of the projection, 2020-2027, prescription drug spending is expected to grow by 6.1 percent per year on average, influenced by higher use anticipated from new drugs and efforts by employers and insurers that encourage patients with chronic conditions to treat their disease.[2]

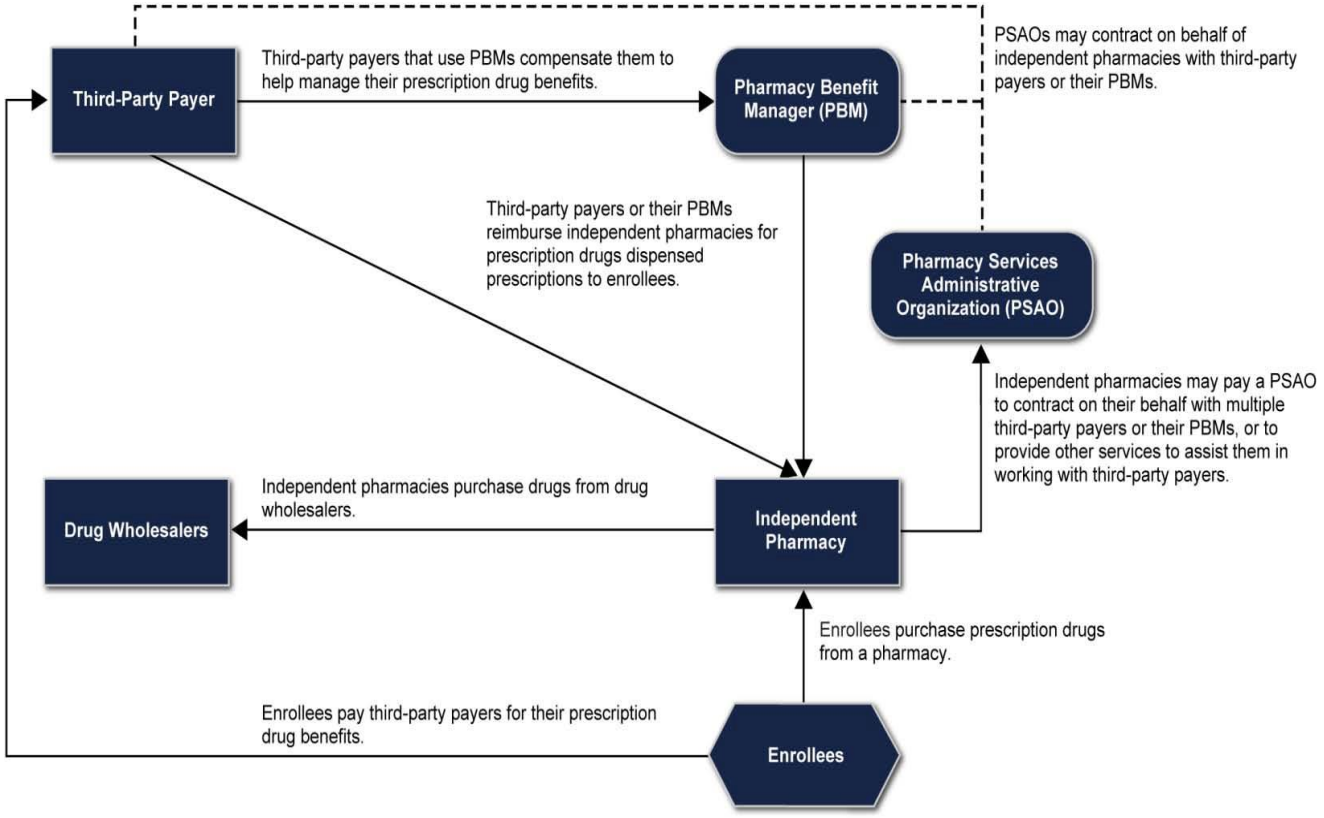
The Drug Supply Chain

The affordability of prescription drugs has gained attention at the state and federal level. In recent years, PBMs and drug manufacturers have come under scrutiny as policymakers have attempted to understand their role in the drug supply chain. Many stakeholders (drug manufacturers, drug wholesalers, pharmacy services administrative organizations, pharmacy

[1] *See* National Health Expenditure Projections 2018-2027, Forecast Summary, The Office of the Actuary in the Centers for Medicare & Medicaid Services, *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf* (last viewed Nov. 20, 2019).
[2] *Id.*

benefit managers, health plans, employers, and consumers) are involved with, and pay different prices for, prescription drugs as they move from the drug manufacturer to the insured.

In general, manufacturers develop and sell their drugs to wholesalers, and wholesalers then sell the drugs to pharmacies. With limited time and resources, some independent pharmacies may need assistance in interacting with these entities, particularly with third-party payers that include large private and public health plans. Many use a pharmacy services administrative organization (PSAO) to interact on their behalf. The PSAOs develop networks of pharmacies by signing contractual agreements with each pharmacy that authorizes them to negotiate with third-party payers on the pharmacy's behalf. Drug wholesalers and independent pharmacy cooperatives owned the majority of PSAOs in operation in 2011 or 2012.[3] Health insurers, HMOs, or employers may contract with PBMs to manage their prescription drug benefits.. The interaction among key entities involved in the distribution and payment of prescription drugs is depicted below:[4]



Source: GAO analysis based on interviews and industry reports.

[3] General Accounting Office, *The Number, Role, and Ownership of Pharmacy Services Administrative Organizations* (GAO-13-176) (Feb 28, 2013) at https://www.gao.gov/products/GAO-13-176 (last viewed Jan. 20, 2020).
[4] *Id.*

A Study of 15 Large Employer Plans[5]

In response to concerns about rising drug costs, a recent study evaluated drug utilization from plan sponsors to estimate savings from reducing the use of high cost, low-value drugs and described some of the cost concerns and challenges relating to the drug supply chain, as follows:

> PBMs negotiate with pharmaceutical manufacturers for price discounts, which are typically paid as rebates based on sales volumes driven by formulary placement. Rebates can reduce the final net price to the plan sponsor and may be passed on to patients. However, in exchange for low administration fees, plan sponsors allow PBMs to keep a portion of the negotiated rebates and other fees. Contracts between PBMs and plan sponsors contain rebate guarantees, perpetuating the demand for high-rebate drugs by encouraging PBMs to maximize rebate revenue, giving preference to some drugs over others on formularies based on rebate revenue rather than their value and final cost to the patient or plan sponsor. Additionally, PBMs earn revenue from "spread" pricing, which is the difference between what PBMs pay pharmacies on behalf of plan sponsors and what PBMs are reimbursed by the plan sponsor. This also encourages PBMs to prioritize higher-cost drugs to allow for a larger spread.

The report[6] further describes additional factors, which may increase costs for employers and insureds:

> …plan sponsors often allow broad formularies that include wasteful drugs because they are concerned that employees will be disappointed if their prescribed drugs are not covered. Doctors prescribe these drugs because they are often unaware of drug costs. Pharmaceutical manufacturers contribute to these patterns by promoting their products through "detailers" — pharmaceutical salespeople calling on doctors — when less costly alternatives may be clinically appropriate for patients. Plan sponsors have addressed the resulting high spending by increasing patient cost-sharing on lower-value drugs. Manufacturers counteract cost-sharing and formulary management tools by flooding the market with copayment coupons that undermine the benefit structure put in place by plan sponsors.

Pharmacy Benefit Managers

Many public and private employers and health plans contract with PBMs to help control drug costs. While PBMs provide pharmacy claims processing and mail-order pharmacy services to their customers, many provide additional services, including rebate negotiations with drug manufacturers, development of pharmacy networks, drug formulary management, prospective and retrospective drug utilization reviews, generic drug substitutions, and disease management. A recent report found that PBMs passed through 78 percent of manufacturer rebates to health

[5] Vela, Lauren, *Reducing Wasteful Spending in Employers' Pharmacy Benefit Plans* (Aug. 2019) the Commonwealth Fund at https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/reducing-wasteful-spending-employers-pharmacy-benefit-plans (last viewed Jan. 3, 2020).
[6] *Id.*

plans in 2012 and 91 percent in 2016.[7] For the same period, the report noted that manufacturer rebates grew from $39.7 billion to $89.5 billion, and played a growing role in partially offsetting increases in list prices, which the study noted have risen more quickly than overall retail prescription drug spending.[8]

In 2018, three companies processed about 75 percent of all equivalent prescription claims: CVS Health (including Caremark and Aetna), Express Scripts, and the OptumRx business of UnitedHealth. The top six PBMs handled more than 95 percent of the total U.S. equivalent prescription claims managed.[9] The top six PBMs were:

- CVS Health (Caremark)/Aetna, 30 percent
- Express Scripts, 23 percent
- OptumRx (UnitedHealth), 23 percent
- Humana Pharmacy Solutions, 7 percent
- Medimpact Healthcare Systems, 6 percent
- Prime Therapeutics, 6 percent

Reimbursement of Pharmacies by PBMs

Generally, a contract between a PBM and a health plan sponsor or employer specify the amount a plan or employer will pay a PBM for brand name and generic drugs. These prices are typically set as a discount off the average wholesale price for brand-name drugs and at a maximum allowable cost (MAC) for generic drugs (and sometimes brand drugs that have generic versions), plus a dispensing fee. The MAC represents the upper limit price that a plan will pay or reimburse for generic drugs and sometimes brand drugs that have generic versions available (multisource brands). A MAC pricing list creates a standard reimbursement amount for identical products.

A MAC pricing list is a common cost management tool that is developed from a proprietary survey of wholesale prices existing in the marketplace, taking into account market share, inventory, reasonable profit margins, and other factors. One of the purposes of the MAC pricing list is to ensure that the pharmacy or their buying groups are motivated to seek and purchase generic drugs at the lowest price in the marketplace. If a pharmacy procures a higher-priced product, the pharmacy may not make as much profit or in some instances may lose money on that specific purchase. If a pharmacy purchases generic drugs at a more favorable price, they will be more likely to make a profit.

Retail Pharmacies

Independent pharmacies[10] are a type of retail pharmacy with a store-based location—often in rural and underserved areas—that dispense medications to consumers, including both prescription and over-the-counter drugs. Nationwide, the number of independent pharmacies in

[7] Reynolds, Ian, et. al., *The Prescription Drug Landscape, Explored* (Mar. 2019). The Pew Charitable Trusts.
[8] *Id.* There were 123 survey responses comprised of 114 individuals from commercial, managed Medicaid, and Medicare Part D health plans and 9 from PBMs.
[9] Drug Channels, CVS, Express Scripts, and the Evolution of the PBM Business Model (May 29, 2019) at https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.html (last viewed Jan. 10, 2020).
[10] One definition of an independent provides that a pharmacy is considered independent if the total store count is fewer than four stores. *See* https://www.pharmacist.com/sites/default/files/files/Profile_16_Independent_SDS_FINAL_090307.pdf (last viewed Jan. 20, 2020).

the United States continues to decline. In 2010, there were 23,106 independent pharmacies; by 2017, that number had dropped to 21,909.[11] Another report[12] noted that the number of independent retail pharmacies in Florida increased 32.4 percent from 2010 to 2019. During that same period, the number of independent retail pharmacists peaked in 2017 at 1,735, and declined to 1,541 in 2019.[13]

The decision of employers, HMOs, or insurers to contract with PBMs may shift business away from smaller retail pharmacies that are also known as independent pharmacies. Historically, independent pharmacies were important health care providers in their communities and their pharmacists had long-term relationships with their patients.[14] However, many independent pharmacies have closed in recent years because of the competition resulting from the proliferation of large, chain retail pharmacies[15] that can negotiate with PBMs at deeply discounted reimbursement levels based on large volume sales. In 2018, further innovation and competition in the marketplace occurred with Amazon acquiring PillPack, a mail-order pharmacy, which has pharmacy licenses in all 50 states.[16] One report noted that Amazon has begun the process of undercutting prices of over the counter medications. [17] Further, some Amazon prices are 20 percent lower than brand medications sold at Walgreens and CVS.[18]

Regulation of Health Insurance in Florida

The OIR licenses and regulates insurers, HMOs, and other risk-bearing entities.[19] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[20] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[21] As part of the certification process used by the 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.[22]

Section 641.234, F.S., authorizes the OIR to require a HMO to submit any contract for administrative services, contract with a provider other than an individual physician, contract for management services, and contract with an affiliated entity to the OIR. After review of a

---

[11] Arnold, Karen, *Independent Pharmacies: Not Dead Yet*, (Jan. 12, 2019, vol. 163, issue 1) Drug Topics, Voice of the Pharmacist.
[12] Quest Analytics analysis of NCPDP Pharmacy Count Data, 2019. Provided by PCMA. On file with Banking and Insurance Committee.
[13] *Id.*
[14] Independent pharmacies are a type of retail pharmacy with a store-based location—often in rural and underserved areas—that dispense medications to consumers, including both prescription and over-the-counter drugs. See http://www.gao.gov/assets/660/651631.pdf (last viewed Jan. 19, 2020).
[15] Such as Walmart, CVS, Walgreens, Publix or Kroger.
[16] Garcia, Ahiz, *Amazon rolls out "Amazon Pharmacy" branding to PillPack*, CNN Business (Nov. 15, 2019) at *https://www.cnn.com/2019/11/15/tech/amazon-pharmacy-pillpack/index.html* (last viewed Jan. 22, 2020).
[17] Cauley, Michael, *Amazon: What Will be its Impact on Community Pharmacy?* https://www.managedhealthcareconnect.com/blog/amazon-what-will-be-its-impact-community-pharmacy
[18] *Id.*
[19] Section 20.121(3)(a)1., F.S.
[20] Sections 624.401 and 641.21(1), F.S.
[21] Section 641.49, F.S.
[22] Section 641.495, F.S.

contract, the OIR may order the HMO to cancel the contract in accordance with the terms of the contract and applicable law if it determines:

- That the fees to be paid by the health maintenance organization under the contract are so unreasonably high as compared with similar contracts entered into by the HMO or as compared with similar contracts entered into by other HMOs in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the HMO; or
- That the contract is with an entity that is not licensed under state statutes, if such license is required, or is not in good standing with the applicable regulatory agency.

Oversight of PBMs

In 2018, legislation was enacted to require PBMs to register with the OIR, effective January 1, 2019, and impose contractual provisions on insurers or HMOs and their PBMs.[23] The law defined a PBM as a person or entity doing business in Florida, which contracts to administer prescription drug benefits on behalf of a health insurer or a HMO to residents of Florida.[24]

Registration. The registration process requires an applicant to remit a nonrefundable fee not to exceed $500, a copy of certain corporate documents, and a completed registration form. Registration and registration renewal certificates are valid for 2 years and are nontransferable.[25] Registrants must report any change in the registration information within 60 days of the change to the OIR.

Contract Provisions. The 2018 law also repealed provisions in the Florida Pharmacy Act, s. 465.1862; F.S., relating to PBM contracts, and transferred them to the insurance code.[26] These provisions require contracts between health insurers or HMOs and PBMs to:

- Require the PBM to update the maximum allowable cost (MAC) pricing information at least once every 7 calendar days;
- Require the PBM to maintain a process that will eliminate drugs from the MAC lists or modify drug prices in a timely manner to remain consistent with changes in pricing data;
- Prohibit the PBM from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244, F.S.
- Prohibit the PBM from requiring an insured to pay for a prescription drug at the point of sale in an amount that exceeds the lesser of:
  - The applicable cost sharing amount; or
  - The retail price of the drug in the absence of prescription drug coverage.

Maximum Allowable Cost. The 2018 law also creates the definition of the term, "maximum allowable cost" (MAC) to mean the per-unit amount that a PBM reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

[23] Ch. 2018-91, s. 3, L.O.F.
[24] Section 624.490, F.S.
[25] *Id.*
[26] *See ss. 627.64741, 627.6572, and 641.314, F.S.*

However, the legislation did not provide the OIR with enforcement authority over PBMs to ensure compliance with these contractual provisions, such as being able to revoke or suspend a PBM's registration or fine the PBM. Therefore, when the OIR addresses any statutory violations by a PBM, the OIR looks to the insurer or HMO, which contracts with the PBM to fulfill its obligations under the insurance code to resolve the situation.[27]

Payment of claims. Sections 627.6131 and 641.3155, F.S., requires a PBM, acting on behalf of an insurer or HMO, to pay a provider's claim within a prescribed time. Further, the Department of Financial Services reviews alleged violations, relating to claims of providers not paid or denied by the insurer or HMO, pursuant to these provisions.[28]

Florida Pharmacy Act

Pursuant to the Florida Pharmacy Act, a "pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, and an Internet pharmacy. The term "community pharmacy" includes every location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.[29] The term, "independent pharmacy," is not defined.

Section 465.1885, F.S., prescribes the rights of a pharmacy in connection with an audit by a PBM, Medicaid managed care plan, or insurance company. These rights include:

- To be notified at least 7 calendar days before the initial onsite audit.
- To have the onsite audit scheduled after the first 3 calendar days of a month unless the pharmacist consents otherwise.
- To have the audit period limited to 24 months after the date a claim is submitted to or adjudicated by the entity.
- To have an audit that requires clinical or professional judgment conducted by or in consultation with a pharmacist.
- To use the written and verifiable records of a hospital, physician, or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law.
- To be reimbursed for a claim that was retroactively denied for a clerical error, typographical error, scrivener's error, or computer error if the prescription was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged, or the error results in actual financial loss to the entity.
- To receive the preliminary audit report within 120 days after the conclusion of the audit.
- To produce documentation to address a discrepancy or audit finding within 10 business days after the preliminary audit report is delivered to the pharmacy.
- To receive the final audit report within 6 months after receiving the preliminary audit report.
- To have recoupment or penalties based on actual overpayments and not according to the accounting practice of extrapolation.

[27] Office of Insurance Regulation, *2020 Legislative Analysis of SB 1338* (Jan. 2, 2020).
[28] Department of Financial Services, *Medical Providers, find out who to contact about your claim payment concerns* at https://apps.fldfs.com/eservice/MedicalProvider.aspx (last viewed Jan. 22, 2020).
[29] Section 465.003(11), F.S.

However, the Department of Health nor the Board of Pharmacy has authority under ch. 465, F.S., the Florida Pharmacy Act, to enforce these provisions against any entity not complying with these requirements.

State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (department), through the Division of State Group Insurance (DSGI), administers the State Group Insurance program under a cafeteria plan consistent with s. 125, Internal Revenue Code. To administer the program, the department contracts with third-party administrators for self-insured health plans, fully insured HMOs, and a Pharmacy Benefits Manager (PBM) for the self-insured State Employees' Prescription Drug Program (program) pursuant to s.110.12315, F.S.

The program has four dispensing avenues: participating 30-day retail pharmacies, participating 90-day retail pharmacies, the PBM's mail order pharmacies, and the PBM's specialty pharmacies. The retail network provides 3,961 pharmacies within the state of Florida and 59,520 nationally. The only chain pharmacy not included in the program's retail network is Walgreens.

During the invitation to negotiate process, the department determined that using a slightly less broad network provided significant savings to the program while having zero access disruption to members.[30] While the program does offer a mail order pharmacy network in the contract with the current PBM, members are not required to use mail order and may fill their prescriptions for up to a 90-day supply at network retail pharmacies that agree to the same pricing as the mail order. Contractually, and as stated in the benefit documents, specialty drugs, as defined by the PBM, must be dispensed by the PBM's specialty pharmacies. However, the first fill of oncology specialty drugs may be covered when dispensed by a network retail pharmacy. This process allows the patient to obtain the medication as soon as possible while providing time for the prescriber to get the patient set up at the PBM's specialty pharmacy. To assist members and prescribers, the PBM's specialty pharmacies have clinicians trained in each of the clinical disciplines, conditions, and specialties corresponding to the specialty drugs being dispensed.

The program covers all federal legend drugs unless specifically excluded or if prescribed to treat a non-covered medical condition. The program does not have fail first requirements or step therapy. The contract between the PBM and the state requires that 100 percent of all manufacturer payments including rebates must be passed through to the state; and that spread pricing at retail pharmacies is prohibited.

The health plans (PPO and HMOs) and the PBM on behalf of the program each apply their respective medical policy guidelines to determine medical necessity for drugs; none of the plans (medical and Rx) cover experimental and/or investigational drugs and treatments.

Copayments (and coinsurance for high deductible plans) for each drug tier are the same for all members, as follows:

[30] *See* Department of Management Services, *2020 Legislative Analysis of SB 1338 (Jan. 16, 2020).*

Drug Tier	Retail – Up to 30-Day Supply	Retail and Mail – Up to 90-Day Supply and Specialty Medications
Generic	$7	$14
Preferred Brand	$30	$60
Non-Preferred Brand	$50	$100

The State Group Insurance Program typically makes benefit changes on a plan year basis, which is January 1 through December 31. Benefit changes are subject to approval by the Legislature. The current PBM for the State Group Insurance Program is CaremarkPCS Health, LLC (CVS Caremark).

Statewide Provider and Health Plan Claim Dispute Resolution Program

The intent of this program, administered by the Agency for Health Care Administration (agency), is to assist contracted and noncontracted providers and health plans for resolution of claim disputes that are not resolved by the provider and the health plan.[31] The agency contracts with an independent dispute resolution organization to assist health care providers and health plans in order to resolve claim disputes. These services are available to Medicaid managed care providers and health plans. Claims submitted to managed care plans that have been denied in full or in part, or allegedly underpaid or overpaid may be eligible for dispute under the arbitration process.[32]

Federal Regulations Relating to Medical Loss Ratios, Rebates, and Spread Pricing

Insurers, HMOs, and PBMs

Health insurers and HMOs are required to report how much they spend on health care and how much they spend on administrative costs, such as salaries and marketing. If an insurer or HMO spends less than 80 percent (85 percent in the large group market) of premium on medical care and efforts to improve the quality of care, they must refund the portion of premium that exceeds this limit. The 80 percent (or 85 percent) is the medical loss ratio. The PBMs must report rebate information to the health insurers and HMOs, and the insurer or HMO includes this information as a deduction from the amount of incurred claims in the MLR reporting to the Department of Health and Human Services (HHS).[33] The Medicaid plans must also calculate and report medical loss ratios, which must account for rebates and spread pricing, as described below.

Medicaid

According to the Centers for Medicare and Medicaid Services (CMS), states are increasingly reporting instances of spread pricing in Medicaid, including cases in Ohio and Texas, and CMS is concerned that spread pricing is inflating prescription drug costs that are borne by beneficiaries

[31] Section 408.7057, F.S.
[32] *Id.*
[33] Section 2718 of the Public Health Service Act. The HHS has the authority to examine insurers and HMOs and their venders, such as PBMs.

and by taxpayers.[34] Further, if spread pricing is not monitored, a PBM can profit from charging health plans an excess amount above the amount paid to the pharmacy dispensing a drug, which increases Medicaid costs for taxpayers.

According to CMS, spread pricing has been reported predominantly for generic prescriptions. States have raised concerns that PBMs can reimburse pharmacies for generic prescriptions based on lower pricing benchmarks than the benchmarks used for charging Medicaid and CHIP managed care plans for the same prescriptions.
In response to these concerns, the CMS released guidance that prohibits PBMs using spread pricing to upcharge health plans and increase costs for states.[35] For purposes of the medical loss ratio[36] (MLR) regulation, "prescription drug rebates" means any price concession or discount received by the managed care plan or by its PBM, regardless of who pays the rebate or discount.[37] Some possible examples include payments from pharmaceutical manufacturers, wholesalers, and retail pharmacies. Therefore, the amount retained by a PBM under spread pricing would have to be excluded from the amount of claims costs used for calculating the Medicaid managed care plan's MLR. The policy underlying this guidance is that spread pricing should not be used to artificially inflate a Medicaid or CHIP managed care plan's MLR. For purposes of calculating the medical loss ratio, the Medicaid managed care regulations[38] require that prescription drug rebates received and accrued must be deducted from incurred claims. The CMS also interprets this requirement to apply equally regardless of whether the prescription drug rebate is received by the managed care plan (i.e., directly) or by a subcontractor (i.e., indirectly) administering the covered outpatient drug benefit on behalf of the managed care plan.

When a managed care plan subcontracts with a third-party vendor to administer, and potentially provide, a portion of Medicaid covered services to enrollees, the subcontractor must report to the managed care plan all of the underlying data needed for the Medicaid managed care plan to calculate and report the managed care plan's MLR.[39] The regulations at 42 CFR 438.8(k) also require states, through their contracts with managed care plans, to require each managed care plan to submit an annual MLR report.

Drug Pricing Transparency

Due to a lack of transparency in the marketplace, it can be difficult to determine the final price of a prescription drug. Drug companies price discriminate, meaning they sell the same drug to different buyers (wholesalers, health plans, pharmacies, hospitals, government purchasers, and other providers) at different prices. The final price of a drug may include rebates and discounts to

[34] Centers for Medicare and Medicaid Services, *CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers* (May 15, 2019) at https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not (last viewed Jan. 3, 2020).
[35] Centers for Medicare and Medicaid Services, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors* (May 15, 2019) https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf (last viewed Jan. 3, 2020).
[36] CMS regulations require Medicaid and CHIP managed care plans to report an MLR and use an MLR target of 85 percent in developing rates. The 85 percent target means that only 15 percent of the revenue for the managed care plan can be used for administrative costs and profits.
[37] 42 CFR 438.8(e)(2)(ii)(B).
[38] *Id.*
[39] 42 CFR 438.230(c)(1) and 42 CFR 438.8(k)(3).

health plans and pharmacy benefit managers that are not disclosed. Market participants, such as wholesalers, add their own markups and fees. Drug manufacturers may offer direct consumer discounts, such as prescription drug coupons that can be redeemed when filling a prescription at a pharmacy.

Drug pricing transparency requires manufacturers, PBMs, and others to expand public disclosures and report more information on drug pricing to the state or federal government. Strategies may be aimed at various parties:

- Manufacturers – price increases, list prices, pricing policies.
- Pharmacy Benefit Managers (PBMs) – rebates, other roles.
- Insurers – formularies, cost sharing for brand and generic drugs, and utilization management techniques.
- Providers – price markups.
- State agencies – drug expenditures and usage trends.

Federal Reporting

Medicare Part D plans and qualified health plan issuers who have their own PBM or contract with a PBM are required to report to the U.S. Department of Health and Human Services (HHS) aggregate information about rebates, discounts, or price concessions that are passed through to the plan sponsor or retained by the PBM. In addition, the plans must report the difference between the amount the plan pays the PBM and the amount that the PBM pays its suppliers (spread pricing). The reported information is confidential, subject to certain limited exceptions. [40]

State Reporting

In 2016, Vermont approved the first law requiring manufacturer disclosure for drugs that underwent large percentage price increases.[41] Each year, this law requires state regulators to compile a list of 15 drugs used by Vermont residents that experience the largest annual price increases. Manufacturers are required to justify the price increase to the Attorney General. The act requires the Attorney General to provide an annual report to the General Assembly based on the information the Office receives from manufacturers and to post the report on the Office's website.

Oregon established a legislative task force in 2018 (HB 4005) that has developed more than a dozen recommendations for further work, including state agency reporting on the 10 most expensive drugs and the 10 with the highest price increases; manufacturer justification of high prices; insurer explanation of formulary practices; provider disclosure of markups; and evaluation of PBM rebates. Maine also enacted a law in 2018 (LD 1406) requiring the state's APCD to annually report on the price of the state's most frequently prescribed and costliest prescription drugs, and to develop a plan for the collection of cost and pricing information from drug manufacturers.[42]

---

[40] 42 U.S.C. s. 1320b-23.

[41] *See* https://legislature.vermont.gov/Documents/2016/Docs/ACTS/ACT165/ACT165%20Act%20Summary.pdf (last viewed Jan. 11, 2020).

[42] Ario, Joel, *Strategies to Expand Transparency, Enhance Competition and Control Costs: A Toolkit for Insurance Regulators Manatt Health Strategies* (Jul. 2019) at

The California Drug Pricing Reporting Law (the law)[43] is designed to provide greater information about trends and factors relating to drug cost and pricing for policymakers and the public. The law imposes price justification, notification, and reporting requirements on pharmaceutical manufacturers for price increases on their drugs sold to state purchasers, insurers, and pharmacy benefit managers in California. The law requires manufacturers to notify state regulators regarding price increases, too. Further, the law requires insurers and health maintenance organizations to report specified cost information regarding covered prescription drugs and the impact of such cost on premiums. The state is required to compile such information and post the annual report on its website. The state may impose civil penalties against entities failing to comply with the reporting requirements. The law requires manufacturers to provide written notification to:

- Purchasers (insurers, HMOs, pharmacy benefit managers, and state agencies) of a drug price increase that exceeds 16 percent over a 2-year period for any drugs with a wholesale acquisition cost (WAC)[44] of greater than $40. The notice must include a statement regarding whether a change or improvement in the drug necessitates the price increase, and if applicable, a description of such change or improvement. This notification must be provided at least 60 days prior to the effective date of the increase.
- The state for each drug for which an increase in WAC, as described above, occurs, or other specified drug price increases. Manufacturers must provide information regarding such drug's indication and dosage, factors used to increase the WAC, and marketing materials.

In the notice to purchasers, as described above, the manufacturer may limit the disclosure to information that it is in the public domain. The state is required to publish on the internet information submitted by manufacturers to the state, as described above, in a manner that identifies the information on a per-drug basis.

III. Effect of Proposed Changes:

Section 1 amends s. 624.3161, F.S., to authorize the OIR to conduct market conduct examinations of PBMs.

Section 2 transfers s. 465.1885, F.S., and renumbers the section as s. 624.491, F.S., and amends the section to clarify existing requirements and limitations for pharmacy audits by an insurer or HMO or an entity on behalf of the insurer or HMO, including but not limited to a PBM. The section specifies:

- Limits on when audits can be conducted;
- Audit scope;
- Use of a consulting pharmacist;
- Use of written and verifiable records of health care providers to validate pharmacy records;

https://www.naic.org/meetings1908/cmte_b_health_inn_wg_2019_summer_nm_materials_strategies.pdf (last viewed Jan. 3, 2020).

[43] See Cal. Health & Safety Code s. 1367.243, s. 1385.045, s. 127280, s. 127675, s. 127676, s. 127677, s. 127679, s. 127681, s. 127683, s. 127685, and s. 127686 (Senate Bill No. 17, 2017).

[44] Under federal law, the term "wholesale acquisition cost" means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. *See* 42 U.S. Code s. 1395w–3a.

- Retroactive reimbursement for claims denied for certain errors;
- The timeframe for the provision of preliminary audits;
- Allowance for production of preliminary documentation to rebut an audit finding;
- Time period for production of the final audit;
- How final recoupment and penalties are calculated.

The section allows a pharmacy to appeal claim payments that are due as a result of an audit with the Statewide Provider and Health Plan Claim Dispute Resolution Program at the Agency for Health Care Administration.

Section 3 creates s. 624.491, F.S., to require health insurers and HMOs, or a PBM acting on behalf of a health insurer or HMO, to report to OIR annually by March 1, the following information for the preceding policy or contract year:

- The total number of prescriptions that were dispensed.
- The number and percentage of all prescriptions that were provided through retail pharmacies compared to mail-order pharmacies.
- The general dispensing rate, which is the number and percentage of prescriptions for which a generic drug was available and dispensed.
- The aggregate amount and types of rebates, discounts, price concessions, or other earned revenues that the health insurer, HMO, or PBM negotiated for and are attributable to patient utilization under the plan, excluding bona fide service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs. If negotiated by the pharmacy benefit manager, the aggregate amount of the rebates, discounts, or price concessions, which were passed through to the health insurer or HMO. These provisions are consistent with the current federal PBM transparency reporting requirements.
- If the health insurer or HMO contracted with a PBM, the aggregate amount of the difference between the amount the health insurer or HMO paid the PBM and the amount the PBM paid retail pharmacies and mail order pharmacies.

Sections 4, 5, and 6 amend ss. 627.64741, 627.6572, and 641.14, F.S., respectively, relating to insurance policies and HMO contracts.

The bill defines “brand name drug” as a drug described by the Medi-Span Master Drug Database and has a multi-source code containing an “M” an “O” or an “N” except for a drug with a multi-source code of “O” and “Dispense as Written code” of 3, 4, 5, 6, or 9; or, the drug has an equivalent brand drug designation in the First Database FDB MedKnowledge database.

A “generic drug” is defined as a drug described by Medi-Span with a multi-source code containing a “Y” or an “O” and a “Dispense as Written code” of 3, 4, 5, 6, or 9; or the drug has an equivalent generic designation in the First Databank FDB MedKnowledge database.

The definition of the term, “maximum allowable cost” is revised to mean the per unit amount that a pharmacy benefit manager reimburses a pharmacist for prescription drugs:

- As specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, a brand name drug, biological product, or a specialty drug;
- Which amount must be based on the pricing published in the Medi-Span Master Drug Database or, if the pharmacy only uses the First Databank FDB Medknowledge, the pricing must be based on the price published in First Databank FDB Medknowledge; and
- Which excludes dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

The bill provides that drugs identified as brand name drugs must be considered brand name drugs for all purposes under an agreement, contract, or amendment to a contract between a PBM and a pharmacy, or a pharmacy services organization on behalf of a pharmacy. A single source generic drug with only one manufacturer must be reimbursed as if it were a brand name drug. A drug identified as a generic drug must be considered a generic drug for all purposes under an agreement, contract, or amendment between a PBM and a pharmacy, or a pharmacy services organization on behalf of a pharmacy. A PBM and the pharmacy, or a pharmacy services administrative organization on behalf of the pharmacy, must agree that if any rebate or other financial benefit for a generic drug is provided to the PBM, the PBM shall only serve as a pass-through to the health insurer or HMO.

Further, the sections provide that a health insurer or HMO may only contract with a PBM that:
- Updates its maximum allowable cost pricing information at least every 7 days.
- Maintains a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.
- Does not limit a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug.
- Does not require an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of the applicable cost-sharing amount or the retail price in the absence of prescription drug coverage.

The sections also provide that the OIR may require any health insurer or HMO to submit any PBM contract or amendment for the administration of pharmacy benefits to the office for review. After review of the contract, the OIR may order the health insurer or HMO to cancel the contract in accordance with the contract terms and applicable law if any of the following conditions exist:
- The PBM fees paid by the health insurer or HMO are unreasonably high compared to similar contracts entered by health insurers or HMOs, or as compared to similar contracts in similar circumstances, that the contract is detrimental to the policyholders or subscribers of the insurer or HMO.
- The contract does not comply with the code.
- The PBM is not registered with the OIR pursuant to s. 624.490, F.S.

Section 7 provides that this bill takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill provides pharmacies with a process to appeal PBM audit filings relating to claim payments with the Statewide Provider and Health Plan Claim Dispute Resolution Program. The bill also provides statutory requirements for audits of pharmacies by PBMs.

The bill provides greater PBM transparency by requiring PBMs to submit an annual report to the OIR, which is consistent with a current federal reporting requirement.

C. Government Sector Impact:

Office of Insurance Regulation

The OIR will need pharmacy-related training and/or a contract with a pharmacist in order to provide effective oversight of PBM market conduct examinations and respond to any complaints involving pharmacy audits. The minimum estimated cost to contract with a pharmacist would be $100,000 - $200,000 (contracted services).[45]

[45] Office of Insurance Regulation, *2020 Agency Legislative Bill Analysis of SB 1338* (Jan. 2, 2020).

Division of State Group Insurance/Department of Management Services (DSGI)[46]

According to CVS/Caremark, the fiscal impact of these definition changes to DSGI would be an increase in plan cost of $8.82M, which is $2.05 per member per month or $24.57 per member per year. There would be an increase in total member cost of $1.7M. The calculations used are:

- Approximately 70K claims that would change from generic to brand drugs. All these claims would now be at the brand-drug rates and members would have to pay the brand-drug copayments.
- Approximately 3,000 claims that would change from brand to generic drugs. All these claims would now be at the generic rates and members would pay the generic copayments.

VI. Technical Deficiencies:

Sections 4, 5, and 6 include terms, which are not defined, such as "pharmacy services administrative organization", "rebate", and "other financial benefit."

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 624.3161, 627.64741, 627.6572, and 641.314.

This bill creates section 624.491 of the Florida Statutes.

This bill repeals section 465.1885 of the Florida Statutes.

IX. Additional Information:

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

Banking and Insurance on January 28, 2020:
The CS provides a technical change to correct a scrivener's error.

B. Amendments:

None.

[46] Department of Management Services, *2020 Agency Legislative Bill Analysis of SB 1338* (Jan. 16, 2020).

632656

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
01/28/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Before line 44
insert:
Section 1. Present paragraphs (a) through (e) of subsection (1) of section 409.975, Florida Statutes, are redesignated as paragraphs (b) through (f), respectively, a new paragraph (a) is added to that subsection, and paragraph (c) of that subsection is amended, to read:
409.975 Managed care plan accountability.—In addition to

 632656

the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) A managed care plan may not exclude from its network an independent pharmacy that meets credentialing requirements, complies with agency standards, and accepts the terms of the plan. The managed care plan must offer the same rate of reimbursement to all pharmacies in the plan's network. As used in this paragraph, the term "independent pharmacy" means a community pharmacy, as defined in s. 465.003(11)(a)1., which has only one location in this state.

(c) After 12 months of active participation in a plan's network, the plan may exclude any essential provider from the network for failure to meet quality or performance criteria. If the plan excludes an essential provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days before the effective date of the exclusion. For purposes of this paragraph, the term "essential provider" includes providers determined by the agency to be essential Medicaid providers under paragraph (b) ~~(a)~~ and the statewide essential providers specified in paragraph (c) ~~(b)~~.

Section 2. Section 624.493, Florida Statutes, is created to

632656

read:

624.493 Pharmacy benefit managers; network providers.—A pharmacy benefit manager may not exclude from its network an independent pharmacy that meets credentialing requirements, complies with the pharmacy benefit manager's standards, and accepts the terms of the pharmacy benefit manager contract. The pharmacy benefit manager must offer the same rate of reimbursement to all pharmacies in the pharmacy benefit manager's network. As used in this section, the term "independent pharmacy" means a community pharmacy, as defined in s. 465.003(11)(a)1., which has only one location in this state.

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

And the title is amended as follows:

Between lines 2 and 3

insert:

amending s. 409.975, F.S.; prohibiting a Medicaid managed care plan from excluding certain independent pharmacies from its network; requiring a managed care plan to offer the same rate of reimbursement to all pharmacies in its network; defining the term "independent pharmacy"; creating s. 624.493, F.S.; prohibiting a pharmacy benefit manager from excluding certain independent pharmacies from its network; requiring a pharmacy benefit manager to offer the same rate of reimbursement to all pharmacies in its network; defining the term "independent pharmacy";

275668

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/28/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 146 - 148

and insert:

Section 3. Section 624.492, Florida Statutes, is created to read:

624.492 Health insurer, health maintenance organization,

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

And the title is amended as follows:

275668

Delete line 15

and insert:

624.492, F.S.; providing applicability; requiring

422030

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
01/28/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 510 and 511
insert:

Section 7. Section 627.444, Florida Statutes, is created to read:

627.444 Health insurers; prescription drug spending reports.—

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

(a) "Specialty drug" means a prescription drug on a health

422030

insurer's formulary which is also covered under Medicare Part D and exceeds the specialty tier cost threshold established by the federal Centers for Medicare and Medicaid Services.

(b) "Utilization management" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings.

(2) By February 1 of each year, each health insurer shall submit to the office a report including all of the following information across all health insurance policies for the preceding calendar year:

(a) The names of the 25 most frequently prescribed prescription drugs.

(b) The percentage of any increase in annual net spending for prescription drugs.

(c) The percentage of any increase in premiums which was attributable to prescription drugs.

(d) The percentage of specialty drugs with utilization management requirements prescribed.

(e) Any premium reductions that were attributable to specialty drug utilization management.

(3) A report submitted under this section may not disclose the identity of a specific health insurance policy or the price charged for a specific prescription drug or class of prescription drugs.

(4) By May 1 of each year, the office shall publish on its website aggregated data from all reports it received under this section for that year. The data from the reports may not be published in a manner that would disclose or tend to disclose

422030

any health insurer's proprietary or confidential information.

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

Section 8. Section 641.262, Florida Statutes, is created to read:

641.262 Prescription drug spending reports.—

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

(a) "Specialty drug" means a prescription drug on a health maintenance organization's formulary which is also covered under Medicare Part D and exceeds the specialty tier cost threshold established by the federal Centers for Medicare and Medicaid Services.

(b) "Utilization management" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings.

(2) By February 1 of each year, each health maintenance organization shall submit to the office a report including all of the following information across all health maintenance contracts for the preceding calendar year:

(a) The names of the 25 most frequently prescribed prescription drugs.

(b) The percentage of any increase in annual net spending for prescription drugs.

(c) The percentage of any increase in premiums which was attributable to prescription drugs.

(d) The percentage of specialty drugs with utilization management requirements prescribed.

(e) Any premium reduction that was attributable to

specialty drug utilization management.

(3) A report submitted under this section may not disclose the identity of a specific health maintenance contract or the price charged for a specific prescription drug or class of prescription drugs.

(4) By May 1 of each year, the office shall publish on its website aggregated data from all reports it received under this section for that year. The data from the reports may not be published in a manner that would disclose or tend to disclose any health maintenance organization's proprietary or confidential information.

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

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

And the title is amended as follows:

Between lines 39 and 40

insert:

creating ss. 627.444 and 641.262, F.S.; defining the terms "specialty drugs" and "utilization management"; requiring health insurers and health maintenance organizations to annually report to the office specified prescription drug spending information across all of their health insurance policies and health maintenance contracts, respectively; prohibiting the disclosure of certain information in the reports; requiring the office to annually publish a certain report on its website; prohibiting the publication of data in the report in a certain manner;

422030

authorizing the commission to adopt rules;

By Senator Wright

14-01655-20 20201338__

A bill to be entitled

An act relating to prescription drug coverage; amending s. 624.3161, F.S.; authorizing the Office of Insurance Regulation to examine pharmacy benefit managers; specifying that certain examination costs are payable by persons examined; transferring, renumbering, and amending s. 465.1885, F.S.; revising entities conducting pharmacy audits to which certain requirements and restrictions apply; authorizing audited pharmacies to appeal certain findings; providing that health insurers and health maintenance organizations that transfer a certain payment obligation to pharmacy benefit managers remain responsible for certain violations; creating s. 624.491, F.S.; providing applicability; requiring health insurers and health maintenance organizations, or pharmacy benefit managers on behalf of health insurers and health maintenance organizations, to annually report specified information to the office; requiring reporting pharmacy benefit managers to also provide the information to health insurers and health maintenance organizations they contract with; authorizing the Financial Services Commission to adopt rules; amending ss. 627.64741, 627.6572, and 641.314, F.S.; defining and redefining terms; specifying requirements relating to brand-name and generic drugs in contracts between pharmacy benefit managers and pharmacies or pharmacy services administration organizations; requiring an agreement for pharmacy

14-01655-20 20201338__

benefit managers to pass through certain financial benefits to the individual or group health insurer or health maintenance organization, respectively; authorizing the office to require health insurers or health maintenance organizations to submit certain contracts or contract amendments to the office; authorizing the office to order insurers or health maintenance organizations to cancel such contracts under certain circumstances; authorizing the commission to adopt rules; revising applicability; providing an effective date.

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

Section 1. Subsections (1) and (3) of section 624.3161, Florida Statutes, are amended to read:

624.3161 Market conduct examinations.—

(1) As often as it deems necessary, the office shall examine each pharmacy benefit manager, each licensed rating organization, each advisory organization, each group, association, carrier, as defined in s. 440.02, or other organization of insurers which engages in joint underwriting or joint reinsurance, and each authorized insurer transacting in this state any class of insurance to which the provisions of chapter 627 are applicable. The examination shall be for the purpose of ascertaining compliance by the person examined with the applicable provisions of chapters 440, 624, 626, 627, and 635.

(3) The examination may be conducted by an independent

professional examiner under contract to the office, in which case payment shall be made directly to the contracted examiner by the insurer or person examined in accordance with the rates and terms agreed to by the office and the examiner.

Section 2. Section 465.1885, Florida Statutes, is transferred, renumbered as s. 624.491, Florida Statutes, and amended to read:

624.491 ~~465.1885~~ Pharmacy audits; rights.—

(1) A health insurer or health maintenance organization providing pharmacy benefits through a major medical individual or group health insurance policy or health maintenance contract, respectively, shall comply with the requirements of this section when the insurer or health maintenance organization or any entity acting on behalf of the insurer or health maintenance organization, including, but not limited to, a pharmacy benefit manager, audits the records of a pharmacy licensed under chapter 465. Such audit must comply with the following requirements ~~If an audit of the records of a pharmacy licensed under this chapter is conducted directly or indirectly by a managed care company, an insurance company, a third-party payor, a pharmacy benefit manager, or an entity that represents responsible parties such as companies or groups, referred to as an "entity" in this section, the pharmacy has the following rights~~:

(a) The pharmacy must ~~To~~ be notified at least 7 calendar days before the initial onsite audit for each audit cycle.

(b) An ~~To have the~~ onsite audit may not be scheduled during ~~after~~ the first 3 calendar days of a month unless the pharmacist consents otherwise.

(c) The scope of ~~To have~~ the audit period must be limited

to 24 months after the date a claim is submitted to or adjudicated by the entity.

(d) ~~To have~~ An audit that requires clinical or professional judgment must be conducted by or in consultation with a pharmacist.

(e) A pharmacy may ~~To~~ use the written and verifiable records of a hospital, physician, or other authorized practitioner, which are transmitted by any means of communication, to validate the pharmacy records in accordance with state and federal law.

(f) A pharmacy must ~~To~~ be reimbursed for a claim that was retroactively denied for a clerical error, typographical error, scrivener's error, or computer error if the prescription was properly and correctly dispensed, unless a pattern of such errors exists, fraudulent billing is alleged, or the error results in actual financial loss to the entity.

(g) A copy of ~~To receive~~ the preliminary audit report must be provided to the pharmacy within 120 days after the conclusion of the audit.

(h) A pharmacy may ~~To~~ produce documentation to address a discrepancy or audit finding within 10 business days after the preliminary audit report is delivered to the pharmacy.

(i) A copy of ~~To receive~~ the final audit report must be provided to the pharmacy within 6 months after receipt of ~~receiving~~ the preliminary audit report.

(j) Any ~~To have~~ recoupment or penalties must be calculated based on actual overpayments and not according to the accounting practice of extrapolation.

(2) ~~The rights contained in~~ This section does ~~do~~ not apply

to:

(a) Audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data or statements, or other investigative methods;

(b) Audits of claims paid for by federally funded programs; or

(c) Concurrent reviews or desk audits that occur within 3 business days after ~~of~~ transmission of a claim and where no chargeback or recoupment is demanded.

(3) An entity that audits a pharmacy located within a Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force area designated by the United States Department of Health and Human Services and the United States Department of Justice may dispense with the notice requirements of paragraph (1)(a) if such pharmacy has been a member of a credentialed provider network for less than 12 months.

(4) Pursuant to s. 408.7057 and after receipt of the final audit report issued by the health insurer or health maintenance organization, a pharmacy may appeal the findings of the final audit as to whether a claim payment is due or the amount of a claim payment.

(5) If a health insurer or health maintenance organization transfers to a pharmacy benefit manager through a contract the obligation to pay any pharmacy licensed under chapter 465 for any pharmacy benefit claims arising from services provided to or for the benefit of any insured or subscriber, the health insurer or health maintenance organization remains responsible for any violations of this section, s. 627.6131, or s. 641.3155.

Section 3. Section 624.491, Florida Statutes, is created to read:

624.491 Health insurer, health maintenance organization, and pharmacy benefit manager reporting requirements.—

(1) This section applies to:

(a) A health insurer or health maintenance organization issuing, delivering, or issuing for delivery comprehensive major medical individual or group insurance policies or health maintenance contracts, respectively, in this state; and

(b) A pharmacy benefit manager providing pharmacy benefit management services on behalf of a health insurer or health maintenance organization described in paragraph (a) and managing prescription drug coverage under a contract with the health insurer or health maintenance organization.

(2) By March 1 annually, a health insurer or health maintenance organization, or a pharmacy benefit manager on behalf of a health insurer or health maintenance organization, shall report, in a form and manner as prescribed by the commission, the following information to the office with respect to services provided by the health insurer or health maintenance organization, or the pharmacy benefit manager on behalf of the insurer or health maintenance organization, for the immediately preceding policy or contract year:

(a) The total number of prescriptions that were dispensed.

(b) The number and percentage of all prescriptions that were provided through retail pharmacies compared to mail-order pharmacies. This paragraph applies to pharmacies licensed under chapter 465 which dispense drugs to the general public and which were paid by the health insurer, health maintenance

organization, or pharmacy benefit manager under the contract.

(c) For retail pharmacies and mail-order pharmacies described in paragraph (b), the general dispensing rate, which is the number and percentage of prescriptions for which a generic drug was available and dispensed.

(d) The aggregate amount and types of rebates, discounts, price concessions, or other earned revenues that the health insurer, health maintenance organization, or pharmacy benefit manager negotiated for and are attributable to patient utilization under the plan, excluding bona fide service fees that include, but are not limited to, distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs.

(e) If negotiated by the pharmacy benefit manager, the aggregate amount of the rebates, discounts, or price concessions under paragraph (d) which were passed through to the health insurer or health maintenance organization.

(f) If the health insurer or health maintenance organization contracted with a pharmacy benefit manager, the aggregate amount of the difference between the amount the health insurer or health maintenance organization paid the pharmacy benefit manager and the amount the pharmacy benefit manager paid retail pharmacies and mail order pharmacies.

(3) A pharmacy benefit manager that reports the information under subsection (2) to the office shall also provide the information to the health insurer or health maintenance organization with which the pharmacy benefit manager is under contract.

(4) The commission may adopt rules to administer this section.

Section 4. Section 627.64741, Florida Statutes, is amended to read:

627.64741 Pharmacy benefit manager contracts.—

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

(a) "Brand-name drug" means a drug that:

1. Is a brand drug described by Medi-Span and has a multisource code field containing an "M" (cobranded product), an "O" (originator brand), or an "N" (single-source brand), except for a drug with a multisource code of "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent brand drug designation in the First Databank FDB MedKnowledge database.

(b) "Generic drug" means a drug that:

1. Is a generic drug described by Medi-Span and has a multisource code field containing a "Y" (generic), or an "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent generic drug designation in the First Databank FDB MedKnowledge database.

(c) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug:

1. As specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand-name drug, biological product, or specialty drug;

2. Which amount must be based on pricing published in the Medi-Span Master Drug Database, or, if the pharmacy benefit

manager uses only First Databank FDB MedKnowledge, must be based on pricing published in First Databank FDB MedKnowledge; and

3. ~~,~~ Excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(d)~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(2) A health insurer may contract only with a pharmacy benefit manager that ~~A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c)~~(3)~~ Does not limit ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d)~~(4)~~ Does not require ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ an insured to make a payment for a prescription drug at the point of sale in an amount that

exceeds the lesser of:

1.~~(a)~~ The applicable cost-sharing amount; or

2.~~(b)~~ The retail price of the drug in the absence of prescription drug coverage.

(3) A drug identified as a brand-name drug must be considered a brand-name drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administration organization on behalf of the pharmacy. A single-source generic drug with only one manufacturer must be reimbursed as if it were a brand-name drug.

(4) A drug identified as a generic drug must be considered a generic drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administrative organization acting on behalf of the pharmacy. The pharmacy benefit manager and the pharmacy, or a pharmacy services administrative organization on behalf of the pharmacy, shall agree that if the pharmacy benefit manager is provided any rebate or other financial benefit for any drug identified as a generic drug, the pharmacy benefit manager must pass through all such rebates or other financial benefits to the health insurer.

(5) The office may require a health insurer to submit to the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer.

(6) After review of a contract under subsection (5), the office may order the insurer to cancel the contract in accordance with the terms of the contract and applicable law if

the office determines that any of the following conditions exist:

(a) The fees to be paid by the insurer are so unreasonably high as compared with similar contracts entered into by insurers, or as compared with similar contracts entered into by other insurers in similar circumstances, that the contract is detrimental to the policyholders of the insurer.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(7) The commission may adopt rules to administer this section.

(8)~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2020 ~~2018~~.

Section 5. Section 627.6572, Florida Statutes, is amended to read:

627.6572 Pharmacy benefit manager contracts.—

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

(a) "Brand-name drug" means a drug that:

1. Is a brand drug described by Medi-Span and has a multisource code field containing an "M" (cobranded product), an "O" (originator brand), or an "N" (single-source brand), except for a drug with a multisource code of "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent brand drug designation in the First Databank FDB MedKnowledge database.

(b) "Generic drug" means a drug that:

1. Is a generic drug described by Medi-Span and has a

multisource code field containing a "Y" (generic), or an "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent generic drug designation in the First Databank FDB MedKnowledge database.

(c) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug:

1. As specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand-name drug, biological product, or specialty drug;

2. Which amount must be based on pricing published in the Medi-Span Master Drug Database, or, if the pharmacy benefit manager uses only First Databank FDB MedKnowledge, must be based on pricing published in First Databank FDB MedKnowledge; and

3. ~~,~~ Excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.

(d)~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health insurer to residents of this state.

(2) A health insurer may contract only with a pharmacy benefit manager that ~~A contract between a health insurer and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or

modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c) ~~(3)~~ Does not limit ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d) ~~(4)~~ Does not require ~~A contract between a health insurer and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1. ~~(a)~~ The applicable cost-sharing amount; or

2. ~~(b)~~ The retail price of the drug in the absence of prescription drug coverage.

(3) A drug identified as a brand-name drug must be considered a brand-name drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and pharmacy, or a pharmacy services administration organization on behalf of the pharmacy. A single-source generic drug with only one manufacturer must be reimbursed as if it were a brand-name drug.

(4) A drug identified as a generic drug must be considered a generic drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administrative organization acting on behalf of the pharmacy. The pharmacy benefit manager

and the pharmacy, or a pharmacy services administrative organization on behalf of the pharmacy, shall agree that if the pharmacy benefit manager is provided any rebate or other financial benefit for any drug identified as a generic drug, the pharmacy benefit manager must pass through all such rebates or other financial benefits to the health insurer.

(5) The office may require a health insurer to submit to the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the insurer.

(6) After review of a contract under subsection (5), the office may order the insurer to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the following conditions exist:

(a) The fees to be paid by the insurer are so unreasonably high as compared with similar contracts entered into by insurers, or as compared with similar contracts entered into by other insurers in similar circumstances, that the contract is detrimental to the policyholders of the insurer.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(7) The commission may adopt rules to administer this section.

(8) ~~(5)~~ This section applies to contracts entered into, amended, or renewed on or after July 1, 2020 ~~2018~~.

Section 6. Section 641.314, Florida Statutes, is amended to

read:

641.314 Pharmacy benefit manager contracts.—

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

(a) "Brand-name drug" means a drug that:

1. Is a brand drug described by Medi-Span and has a multisource code field containing an "M" (cobranded product), an "O" (originator brand), or an "N" (single-source brand), except for a drug with a multisource code of "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent brand drug designation in the First Databank FDB MedKnowledge database.

(b) "Generic drug" means a drug that:

1. Is a generic drug described by Medi-Span and has a multisource code field containing a "Y" (generic), or an "O" and a Dispense as Written code of 3, 4, 5, 6, or 9; or

2. Has an equivalent generic drug designation in the First Databank FDB MedKnowledge database.

(c) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacist for a prescription drug:

1. As specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, brand-name drug, biological product, or specialty drug;

2. Which amount must be based on pricing published in the Medi-Span Master Drug Database, or, if the pharmacy benefit manager uses only First Databank FDB MedKnowledge, must be based on pricing published in First Databank FDB MedKnowledge; and

3. ~~,~~ Excluding dispensing fees, prior to the application of

copayments, coinsurance, and other cost-sharing charges, if any.

(d)~~(b)~~ "Pharmacy benefit manager" means a person or entity doing business in this state which contracts to administer or manage prescription drug benefits on behalf of a health maintenance organization to residents of this state.

(2) A health maintenance organization may contract only with a pharmacy benefit manager that ~~A contract between a health maintenance organization and a pharmacy benefit manager must require that the pharmacy benefit manager~~:

(a) Updates ~~Update~~ maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintains ~~Maintain~~ a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(c)~~(3)~~ Does not limit ~~A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting~~ a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(d)~~(4)~~ Does not require ~~A contract between a health maintenance organization and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring~~ a subscriber to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

1.~~(a)~~ The applicable cost-sharing amount; or

2.~~(b)~~ The retail price of the drug in the absence of prescription drug coverage.

(3) A drug identified as a brand-name drug must be considered a brand-name drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administration organization on behalf of the pharmacy. A single-source generic drug with only one manufacturer must be reimbursed as if it were a brand-name drug.

(4) A drug identified as a generic drug must be considered a generic drug for all purposes under an agreement, contract, or amendment to a contract between a pharmacy benefit manager and a pharmacy, or a pharmacy services administrative organization acting on behalf of the pharmacy. The pharmacy benefit manager and the pharmacy, or a pharmacy services administrative organization on behalf of the pharmacy, shall agree that if the pharmacy benefit manager is provided any rebate or other financial benefit for any drug identified as a generic drug, the pharmacy benefit manager must pass through all such rebates or other financial benefits to the health maintenance organization.

(5) The office may require a health maintenance organization to submit to the office any contract, or amendments to a contract, for the administration or management of prescription drug benefits by a pharmacy benefit manager on behalf of the health maintenance organization.

(6) After review of a contract under subsection (5), the office may order the health maintenance organization to cancel the contract in accordance with the terms of the contract and applicable law if the office determines that any of the

following conditions exist:

(a) The fees to be paid by the health maintenance organization are so unreasonably high as compared with similar contracts entered into by health maintenance organizations, or as compared with similar contracts entered into by other health maintenance organizations in similar circumstances, that the contract is detrimental to the subscribers of the health maintenance organization.

(b) The contract does not comply with the Florida Insurance Code.

(c) The pharmacy benefit manager is not registered with the office pursuant to s. 624.490.

(7) The commission may adopt rules to administer this section.

(8)~~(5)~~ This section applies to pharmacy benefit manager contracts entered into, amended, or renewed on or after July 1, 2020 ~~2018~~.

Section 7. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/2020
Meeting Date

1338
Bill Number (if applicable)

632656
Amendment Barcode (if applicable)

Topic Prescription Drug Coverage

Name Audrey Brown

Job Title President/CEO

Address 200 W. College Ave.
Street

Phone 850-386-3012

Tallahassee FL 32301
City *State* *Zip*

Email audrey@fahp.net

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/2020
Meeting Date

SB 1338
Bill Number (if applicable)

Topic EXCLUSION OF PHARMACIES FROM NETWORK

632656
Amendment Barcode (if applicable)

Name MICHAEL JACKSON

Job Title EVP & CEO

Address 610 N. ADAMS ST
Street

TALLAHASSEE FL 32301
City *State* *Zip*

Phone (850) 222-2400

Email MJACKSON@PHARMVIEW.COM

Speaking: ☐ For ☐ Against ☒ Information

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

Representing FLORIDA PHARMACY ASSOCIATION

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

28 Jan 2020
Meeting Date

1338
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Cynthia Henderson

Job Title _____

Address 108 E. Jefferson St. Suite A
Street

Phone 850 559 0855

Tallahassee
City

FL
State

32301
Zip

Email cyhenderson@me.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing EPIC Pharmacy

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

January 28, 2020
Meeting Date

SB1338
Bill Number (if applicable)

Topic Prescription Drug Coverage

Amendment Barcode (if applicable)

Name Michael Jackson

Job Title Executive Vice President and CEO

Address 610 North Adams Street
Street

Phone (850) 222-2400

Tallahassee
City

Florida
State

32301
Zip

Email mjackson@pharmview.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Pharmacy Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-28-20
Meeting Date

1338
Bill Number (if applicable)

Topic PBM

Amendment Barcode (if applicable)

Name Kevin Duane

Job Title Pharmacist

Address 2579 Kantos Ct
Street

Jacksonville FL 32246
City *State* *Zip*

Phone 904-422-5643

Email KevinC@PanamaRX.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/2020
Meeting Date

CB 1338
Bill Number (if applicable)

Topic Pharmacy Benefits Management

Amendment Barcode (if applicable)

Name James Wright

Job Title Pharmacist

Address 1108 Lake Dr
Street

Phone 321-806-3951

Cocoa FL 32922
City *State* *Zip*

Email James.Wright@Fivepointsrx.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing SelP

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/20
Meeting Date

SB 1338
Bill Number (if applicable)

Topic PBM BILL

Amendment Barcode (if applicable)

Name ALEX HERWIG

Job Title PHARMACIST PHARMACY OWNER

Address 1400 GULF SHORE BLVD N. #100
Street

Phone 239-262-2222

NAPLES FL 34102
City *State* *Zip*

Email ALEX@GULFSHORERX.COM

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

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

Representing SPAR SMALL BUSINESS PHARMACIES ALIGNED FOR RETIRM

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

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

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/2020
Meeting Date

SB 1338
Bill Number (if applicable)

Topic PBM bill

Amendment Barcode (if applicable)

Name Dawn Butterfield

Job Title pharmacist/pharmacy owner

Address 2711 Clearlake Rd #C-10
Street

Cocoa, FL 32922
City *State* *Zip*

Phone 321 305 6909

Email cocoapharmacy@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing SELF

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/20
Meeting Date

1338
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nland

Job Title _____

Address 4427 Herschel St
Street

Jacksonville, FL 32210
City *State* *Zip*

Phone 904-233-3051

Email nlandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Chapter, American College of Physicians
Florida Gastroenterologic Society

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-28-2020
Meeting Date

SB 1338
Bill Number (if applicable)

Topic Prescription Drug Coverage

Amendment Barcode (if applicable)

Name Bill Mincy

Job Title VP PPSC

Address 3375-I Capital Circle NE
Street

Phone 850-322-7740

Tallahassee FL 32308
City *State* *Zip*

Email bill.mincy@ppsconline.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing PPSC/Florida Independent Pharmacy Network

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

28 Jan 20
Meeting Date

1338
Bill Number (if applicable)

Topic Prescription Drug Coverage

Amendment Barcode (if applicable)

Name Barney Bishop III

Job Title CEO

Address 2215 Thomasville Road
Street

Phone 850.510.9922

Tallahassee FL 32308
City *State* *Zip*

Email barney@barneybishop.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Barney Bishop Consulting & SPAR

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/20
Meeting Date

1338
Bill Number (if applicable)

Topic PBM Reform

Amendment Barcode (if applicable)

Name Jeff Kottkamp

Job Title

Address
Street

Phone

1110 Lassen, FL
City *State* *Zip*

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Small Business Pharmacies Alliance for Reform (SPAR)

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28
Meeting Date

5131738
Bill Number (if applicable)

Topic PBMs

Amendment Barcode (if applicable)

Name Connor Rose

Job Title Director, State Affairs PCMA

Address 325 7th St. NW
Street

Washington DC 20004
City *State* *Zip*

Phone 859-797-1420

Email crose@pcmanet.org

Speaking: ☐ For ☑ Against ☐ Information

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

Representing PCMA

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/20
Meeting Date

1338
Bill Number (if applicable)

Topic PBM Reform

Amendment Barcode (if applicable)

Name Toni Large

Job Title

Address 1100 Brookwood DR.
Street

Phone (850) 556-1461

32308
City *State* *Zip*

Email toni@largestrategies.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Florida Society of Rheumatology

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/2020
Meeting Date

1338
Bill Number (if applicable)

Topic Prescription Drug Coverage

Amendment Barcode (if applicable)

Name Audrey Brown

Job Title President/CEO

Address 200 W. College Ave.
Street

Phone 850-386-3012

Tallahassee FL 32301
City *State* *Zip*

Email audrey@fahp.net

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1564
INTRODUCER:	Banking and Insurance Committee and Senator Stargel
SUBJECT:	Use of Genetic Information
DATE:	January 29, 2020 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1564 provides that a life insurer, long-term care insurer, or disability income insurer may use genetic information, including the results of direct-to-consumer genetic testing, for underwriting purposes only if the genetic information is:

- In the medical record;
- Relevant to a potential medical condition that impacts mortality or morbidity risk; and
- Related to expected mortality or morbidity based on sound actuarial principles or reasonably expected experience.

The bill prohibits a life insurer, long-term care insurer, or disability income insurer from:

- Cancelling coverage based solely on genetic information;
- Requiring an applicant take a genetic test as a condition of insurability; or
- Obtaining, requesting, or otherwise requiring the complete genome sequence of an applicant's DNA.

The bill applies the existing prohibition against health insurers using genetic information in the absence of a diagnosis to direct-to-consumer genetic testing.

The bill requires companies that provide direct-to-consumer genetic testing must obtain written consent from the consumer prior to sharing genetic information or personally identifiable information about a consumer with a life insurer or health insurer.

The bill has an effective date of July 1, 2020.

II. Present Situation:

Use of Genetic Information for Insurance Purposes – Florida Requirements

Insurance policies for life, disability income, and long-term care[1] are exempt from s. 627.4301, F.S., which provides standards for the use of genetic information by health insurers. Health insurers[2] may not, in the absence of a diagnosis of a condition related to genetic information, use such information to cancel, limit, or deny coverage, or establish differentials in premium rates. Health insurers are also prohibited from requiring or soliciting genetic information, using genetic test results, or considering a person's decisions or actions relating to genetic testing in any manner for any insurance purpose.

Section 627.4031, F.S., defines "genetic information" to mean information derived from genetic testing to determine the presence or absence of variations or mutations, including carrier status, in an individual's genetic material or genes that are:

- Scientifically or medically believed to cause a disease disorder, or syndrome, or are associated with a statistically increased risk of developing a disease; or
- Associated with a statistically increased risk of developing a disease, disorder, or syndrome, which is producing or showing no symptoms at the time of testing.

Genetic testing, for purposes of s. 627.4031, F.S., does not include routine physical examinations or chemical, blood, or urine analysis, unless specifically conducted to obtain genetic information, or questions regarding family history.

Prohibition of Unfair Discrimination Between Individuals

Insurance policy forms for insurance sold in Florida must be filed and approved by the Office of Insurance Regulation (OIR).[3] The Unfair Insurance Trade Practices Act prohibits "knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class and expectation of life, in the rates charged for a life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other term or condition of such contract."[4] Similarly, the act prohibits knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class, as determined at the time of initial issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance, in benefits payable, in the terms or conditions of the contract, or in any other manner.[5] Genetic information

[1] Section 627.4301(2)(c), F.S. Other types of insurance that are wholly exempt from the statute are accident-only policies, hospital indemnity or fixed indemnity policies, dental policies, and vision policies.
[2] Section 627.4301(1)(b), F.S., defines health insurer to mean, "an authorized insurer offering health insurance as defined in s. 624.603, F.S., a self-insured plan as defined in s. 624.031, F.S., a multiple-employer welfare arrangement as defined in s. 624.437, F.S., a prepaid limited health service organization as defined in s. 636.003, F.S., a health maintenance organization as defined in s. 641.19, F.S., a prepaid health clinic as defined in s. 641.402, F.S., a fraternal benefit society as defined in s. 632.601, F.S., or any health care arrangement whereby risk is assumed."
[3] Section 624.410, F.S.
[4] Section 626.9541(1)(g)1., F.S.
[5] Section 626.9541(1)(g)2., F.S.

used in the underwriting and pricing of life insurance, long-term care insurance, and disability income insurance must meet these requirements.

Genetic Testing – Informed Consent and Privacy Requirements

Section 760.40, F.S., provides that the results of DNA analysis are the exclusive property of the person tested. Accordingly, DNA analysis may be performed only with the informed consent of the person to be tested. The results of DNA analysis, whether held by a public or private entity, are confidential, and may not be disclosed without the consent of the person tested. DNA analysis held by a public entity must be held confidential and exempt from public disclosure. Violation of these requirements is a first degree misdemeanor punishable by up to 1 year imprisonment and a fine of up to $1,000. DNA analysis, for purposes of the statute, is the medical and biological examination and analysis of a person to identify the presence and composition of genes in that person's body, and includes DNA typing and genetic testing.

The law also requires any person who performs DNA analysis or receives records, results, or findings of DNA analysis must provide the person tested with notice that the analysis was performed or the information was received. The notice must state that, upon the request of the person tested, the information will be made available to his or her physician. Further, the notice must state whether the information was used in any decision to grant or deny any insurance, employment, mortgage, loan, credit, or educational opportunity. If such information was used in a denial of the foregoing, the analysis must be repeated to verify the accuracy of the first analysis, and if the first analysis is found to be inaccurate, the denial must be reviewed.

Federal Laws on the Use of Genetic Information for Insurance Purposes

Federal law generally prohibits health insurers from soliciting genetic information and using such information for underwriting purposes. Federal law does not apply these prohibitions to life insurance, disability insurance, or long-term care insurance.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) amended a number of existing federal laws to prohibit health insurers from using genetic information for underwriting purposes.[6] The act does not apply to life insurance, long-term care insurance, or disability insurance.

Title I of GINA provides protections against discrimination by health insurers on the basis of genetic information.[7] GINA prohibits health insurers and health plan administrators from using genetic information to make rating or coverage decisions.[8] These decisions include eligibility for coverage and setting premium or contribution amounts.

[6] Pub. Law No. 110-233, s. 122 Stat. 881-921 (2008). https://www.gpo.gov/fdsys/pkg/PLAW-110publ233/pdf/PLAW-110publ233.pdf (last accessed January 24, 2020).
[7] 110th Congress, *Summary: H.R.493 Public Law* (May 21, 2008) (last accessed January 24, 2020).
[8] *See* 29 USC 1182; 42 USC 300gg-1; and 42 USC 300gg-53.

GINA generally prohibits health insurers and health plan administrators from requesting or requiring genetic information of an individual or the individual's family members,[9] nor may such information be requested, required or purchased for underwriting purposes.[10] Underwriting purposes include rules for eligibility, determining coverage or benefits, cost-sharing mechanisms, calculating premiums or contribution amounts, rebates, payments in kind, pre-existing condition exclusions, and other activities related to the creation, renewal, or replacement of health insurance or health benefits. Underwriting purposes does not include determining medical appropriateness where an individual seeks a health benefit under a plan, coverage, or policy.[11] Genetic information may be used by an insurer to make a determination regarding the payment of benefits, for example, as the basis of a diagnosis that then would lead to benefits being provided under the insurance policy.

The protections in GINA apply to the individual and group health markets, including employer sponsored plans under the Employee Retirement Income Security Act of 1974 (ERISA).[12] GINA generally expanded many of the genetic information protections in the Health Insurance Portability and Accountability Act of 1996[13] (HIPAA) and applied them to the individual, group and Medicare supplemental marketplaces.[14] The protections enacted in GINA do not apply to Medicare or Medicaid because both programs bar the use of genetic information as a condition of eligibility.[15] GINA also prohibits employment discrimination on the basis of genetic information.[16]

States may provide stronger protections than GINA, which provides a baseline level of protection against prohibited discrimination on the basis of genetic information.

Health Insurance Portability and Accountability Act of 1996

HIPAA establishes national standards to ensure the privacy and nondisclosure of personal health information. The rule applies to "covered entities" which means a health plan, health care clearinghouse, other health care providers, and their business associates.[17] HIPAA provides standards for the use and disclosure of protected health information and generally prohibits covered entities and their business associates from disclosing protected health information, except as otherwise permitted or required.[18] Covered entities generally may not sell protected

[9] Department of Health and Human Services, *"GINA" The Genetic Information Nondiscrimination Act of 2008: Information for Researchers and Health Care Professionals*, (April 6, 2009). https://www.genome.gov/Pages/PolicyEthics/GeneticDiscrimination/GINAInfoDoc.pdf (last accessed January 27, 2020).
[10] *See* 29 USC 1182(d); 42 USC 300gg-4(d); and 42 USC 300gg-53(e).
[11] *See* 45 CFR 164.502(a)(5)(i)(4)(B).
[12] Perry W. Payne, Jr. et al, *Health Insurance and the Genetic Information Nondiscrimination Act of 2008: Implications for Public Health Policy and Practice*, Public Health Rep., Vol. 124 (March-April 2009), 328, 331.
[13] Codified 42 USC 300gg, 29 USC 1181 et seq., and 42 USC 1320d et seq.
[14] *See* Payne fn. 12 at pg. 329.
[15] *See id*.
[16] *See* 29 CFR 1635(a), which prohibits the use of genetic information in employment decision making; restricts employers and other entities from requesting, requiring, or purchasing genetic information; requires that genetic information be maintained as a confidential medical record, and places strict limits on disclosure of genetic information; and provides remedies for individuals whose genetic information is acquired, used, or disclosed in violation of GINA.
[17] See 45 CFR 160.103.
[18] See 45 CFR 164.502(a).

health information.[19] HIPPA, as modified by GINA, also prohibits health plans from using or disclosing protected health information that is genetic information for underwriting purposes.[20]

Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act of 2010 (ACA) requires all individual and group health plans to enroll applicants regardless of their health status, age, gender, or other factors that might predict the use of health services.[21] These guaranteed issue and guaranteed renewability requirements apply to genetic testing.

Use of Genetic Information for Insurance Purposes – Requirements in Other States and Canada

Federal law under GINA applies to all states and provides a baseline level of protection that states may exceed. The NIH has identified 106 state statutes addressing health insurance nondiscrimination across 48 states and the District of Columbia.[22] Fewer states address genetic testing regarding other lines of insurance such as life insurance, disability insurance, and long-term care insurance.[23]

Examples of such statutes include Oregon, which requires informed consent to conduct testing, prohibits the use of genetic information for underwriting or ratemaking for any policy for hospital and medical expense, and prohibits using the genetic information of a blood relative for underwriting purposes regarding any insurance policy.[24] Informed consent when an insurer requests genetic testing for life or disability insurance is required in California, New Jersey, and New York.[25] Massachusetts prohibits unfair discrimination based on genetic information or a genetic test and prohibits requiring an applicant or existing policyholder to undergo genetic testing.[26] Arizona prohibits the use of genetic information for underwriting or rating disability insurance in the absence of a diagnosis, and life and disability insurance policies may not use genetic information for underwriting or ratemaking unless supported by the applicant's medical condition, medical history, and either claims experience or actuarial projections.[27]

Canadian Genetic Non-Discrimination Act

In 2017 the Canadian Parliament passed a Genetic Non-Discrimination Act[28] (Canadian Act). The Canadian Act prohibits requiring an individual to undergo a genetic test, or disclose the

[19] See 45 CFR 164.502(a)(5)(ii)(A).
[20] See 45 CFR 164.502(a)(5)(i).
[21] See 42 USC 300gg-1 and 42 USC 300gg-2.
[22] National Institutes of Health, *Genome Statute and Legislation Database Search*. https://www.genome.gov/policyethics/legdatabase/pubsearch.cfm (database search for "state statute," "health insurance nondiscrimination" performed by Committee on Banking and Insurance professional staff on January 24, 2020).
[23] *See id*. (database search for "state statute," "other lines of insurance nondiscrimination" performed by Committee on Banking and Insurance professional staff on January 24, 2020).
[24] Section 746.135, O.R.S.
[25] *See* Cal. Ins. Code s. 10146 et seq.; s. 17B:30-12, N.J.S.; and ISC s. 2615, N.Y.C.L.
[26] Chapter 175 sections 108I and 120E, M.G.L.
[27] Section 20-448, A.R.S.
[28] Statutes of Canada 2017, c. 3. https://laws-lois.justice.gc.ca/eng/acts/G-2.5/page-1.html#h-1 (last accessed January 27, 2020).

results of a genetic test, as a condition of providing goods or services to that individual, entering into or continuing a contract or agreement with that individual, or offering or continuing specific terms or conditions in a contract or agreement with that individual. Thus an insurer could not require an applicant provide genetic testing results. The Canadian Act also requires an individual's written consent prior to using or disclosing the results of a genetic test. The Canadian Act exempts physicians and other health care practitioners in respect to an individual to whom they are providing health services and persons conducting medical, pharmaceutical, or scientific research in respect of an individual who is a participant in the research. Violations of the act are punishable under the criminal law. The Canadian Act is currently being challenged before the Supreme Court of Canada.[29]

Genetic Testing

Genetic testing includes a number of medical tests that identify and examine chromosomes, genes, or proteins for the purpose of obtaining genetic information.[30] Genetic testing is often used for medical or genealogical purposes.

Medical Genetic Testing

Genetic testing can be done to diagnose a genetic disorder, to predict the possibility of future illness, and predict a patient's response to therapy.[31] More than 2,000 genetic tests are currently available and more tests are constantly being developed.[32] The National Institutes of Health[33] (NIH) have identified the following available types of medical genetic testing:[34]

- *Diagnostic testing* identifies or rules out a specific genetic or chromosomal condition, and is often used to confirm a diagnosis when a particular condition is suspected based on the individual's symptoms. For example, a person experiencing abnormal muscle weakness may undergo diagnostic testing that screens for various muscular dystrophies.
- *Predictive and pre-symptomatic testing* is used to detect gene mutations associated with disorders that appear after birth, often later in life. This testing is often used by people who are asymptomatic, but have a family member with a genetic disorder. Predictive testing can identify mutations that will result in a genetic disorder, or that increase a person's risk of developing disorders with a genetic basis, such as cancer.

---

[29] *Canadian Coalition for Genetic Fairness v. Attorney General of Quebec, et. al*, Docket No. 38478 https://www.scc-csc.ca/case-dossier/info/sum-som-eng.aspx?cas=38478 (last accessed January 27, 2020); Leslie MacKinnon, *Genetic Non-Discrimination Bill Passed by Parliament, But Challenged by Government at Top Court*, iPolitics, (Oct 10, 2019) https://ipolitics.ca/2019/10/10/genetic-non-discrimination-bill-passed-by-parliament-but-challenged-by-government-at-top-court/

[30] National Institutes of Health, *Genetic Testing*, pg. 3 (January 30, 2018). Available for download at https://ghr.nlm.nih.gov/primer/testing/uses (last accessed January 27, 2020).

[31] Francis S. Collins, *A Brief Primer on Genetic Testing* (January 24, 2003). https://www.genome.gov/10506784/a-brief-primer-on-genetic-testing/ (last accessed January 24, 2020).

[32] *See* Ohio State University Wexner Medical Center, *Facts About Testing*. https://wexnermedical.osu.edu/genetics/facts-about-testing (last accessed January 24, 2020).

[33] The National Institutes of Health is the medical research agency of the United States federal government. The NIH is part of the United States Department of Health and Human Services. The NIH is made of 27 different Institutes and Centers, each having a specific research agenda.

[34] *See* National Institutes of Health, fn. 30, at pgs. 5-6.

- *Carrier testing* identifies people who carry one copy of a gene mutation that, when present in two copies, causes a genetic disorder. This test is often used by parents to determine their risk of having a child with a genetic disorder.
- *Preimplantation testing* is used to detect genetic changes in embryos developed by assisted reproductive techniques such as in-vitro fertilization. Small numbers of cells are taken from the embryos and tested for genetic changes prior to implantation of a fertilized egg.
- *Prenatal testing* detects changes in a baby's genes or chromosomes before birth. Such testing is often offered if there is an increased risk the baby will have a genetic or chromosomal disorder.
- *Newborn screening* is performed shortly after birth to identify genetic disorders that can be treated early in life. Florida screens for 31 disorders recommended by the United States Department of Health and Human Services Recommended Uniform Screening Panel and 22 secondary disorders, unless a parent objects in writing.[35]

Genetic testing is often used for research purposes. For example, genetic testing may be used to discover genes or increase understanding of genes that are newly discovered or not well understood.[36] Testing results as part of a research study are usually not available to patients or health care providers.[37]

The Human Genome Project, which in April 2003, successfully sequenced and mapped all of the genes of humans, and a variety of other genetic testing, has led to multiple medical advances. For example, genetic testing identified that the reason the drug Plavix, which is commonly used to prevent blood clots in patients at risk for heart attacks and strokes, does not work for approximately 30 percent of the United States population because variations in the CYP2C19 gene account for the lack of a response.[38] Thus, genetic testing can identify persons for whom the drug will not be effective.

The American Medical Association supports broad protections against genetic discrimination because it believes genetic testing and genetic information is essential to advancements in medical knowledge and care.[39] Accordingly, the organization supports comprehensive federal protection against genetic discrimination because "patients remain at-risk of discrimination in a broad array of areas such as life, long-term care, and disability insurance as well as housing, education, public accommodations, mortgage lending, and elections."

Methods of genetic testing used for medical purposes include:

- Molecular genetic tests (Gene tests) that study single genes or short lengths of DNA to identify variations or mutations that lead to a genetic disorder.

---

[35] Florida Department of Health, *Newborn Screening*. http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/index.html (last accessed January 24, 2020).
[36] *See* Ohio State University Wexner Medical Center, fn. 32.
[37] *See* National Institutes of Health, fn. 30, at pg. 24.
[38] Francis S. Collins, Perspectives on the Human Genome Project, pg. 50 (June 7, 2010). https://www.genome.gov/Pages/Newsroom/Webcasts/2010ScienceReportersWorkshop/Collins_NHGRIsciencewriters060710.pdf (last accessed January 27, 2020).
[39] American Medical Association, *Genetic Discrimination – Appendix II. AMA Legislative Principles on Genetic Discrimination and Surreptitious Testing*, (March 2013) https://www.ama-assn.org/sites/default/files/media-browser/public/genetic-discrimination-policy-paper.pdf (last accessed January 24, 2020).

- Chromosomal genetic tests that analyze whole chromosomes or long lengths of DNA to see if there are large genetic changes, such as an extra copy of a chromosome, that cause a genetic condition.
- Biochemical genetic tests that study the amount or activity level of proteins; abnormalities in either can indicate changes to the DNA that result in a genetic disorder.

Genetic Ancestry Testing

Genetic ancestry testing, also called genetic genealogy, is used to identify relationships between families and identify patterns of genetic variation that are often shared among people of particular backgrounds.[40] According to the NIH, genetic ancestry testing results may differ between providers because they compare genetic information to different databases. The tests can yield unexpected results because human populations migrate and mix with other nearby groups. Scientists can use large numbers of genetic ancestry test results to explore the history of populations. Three common types of genetic ancestry testing include:[41]

- Single nucleotide polymorphism testing to evaluate large numbers of variations across a person's entire genome. The results are compared with those of others who have taken the tests to provide an estimate of a person's ethnic background.
- Mitochondrial DNA testing to identify genetic variations in mitochondrial DNA, which provides information about the direct female ancestral lines.
- Y chromosome testing, performed exclusively on males, often used to investigate whether two families with the same surname are related.

Direct to Consumer Genetic Testing

Traditionally, genetic testing was available only through health care providers.[42] Direct-to-consumer genetic testing provides access to genetic testing outside the health care context. Generally, the consumer purchases a genetic testing kit from a vendor that mails the kit to the consumer. The consumer collects a DNA sample and mails it back to the vendor. The vendor uses a laboratory to conduct the test. The consumer is then notified of the test results.

Direct-to-consumer genetic testing has primarily been used for genealogical purposes, but increasing numbers of products now provide medical information. For example, the vendor 23andME offers, with FDA approval, genetic testing that examines the consumer's risks for certain diseases including Parkinson's disease, celiac disease, and late-onset Alzheimer's disease.[43]

Direct to consumer genetic testing is increasing in popularity, with one company reporting having sold approximately 1.5 million genetic testing kits from November 24, 2017, through November 27, 2017.[44] The increased proliferation of such testing is accompanied by increased

[40] *See* National Institutes of Health, fn. 30, at pg. 25.
[41] *See* National Institutes of Health, fn. 30, at pg. 26.
[42] *See* National Institutes of Health, fn. 30, at pg. 11.
[43] 23andMe, *Find Out What Your DNA Says About Your Health, Traits and Ancestry* https://www.23andme.com/dna-health-ancestry/ (last accessed January 24, 2020).
[44] Megan Molteni, *Ancestry's Genetic Testing Kits Are Heading For Your Stocking This Year*, Wired, (December 1, 2017) https://www.wired.com/story/ancestrys-genetic-testing-kits-are-heading-for-your-stocking-this-year/ (last accessed January 24, 2020).

concerns about the privacy of such information. The privacy protections of HIPAA usually do not apply to direct-to-consumer genetic testing because the vendors selling such tests are often not "covered entities" and thus not subject to HIPAA. The Federal Trade Commission has recently warned consumers to consider the privacy implications of genetic testing kits.[45]

Direct-to-consumer genetic testing is being used by law enforcement to identify suspects in crimes.[46] To do so, law enforcement agencies test crime scene DNA samples for DNA markers that in many cases are shared with blood relatives. The DNA markers can then be uploaded to a free online database, GEDmatch, which is used by the public to search for relatives. The DNA database identifies relatives that match the DNA markers, information which can then be used to focus on an individual suspect.

Concerns Over Direct-to-Consumer Genetic Testing Privacy and Fraud

The use of genetic information to identify other family members has public policy implications that are not limited to criminal law. A 2018 study estimated that a genetic database would need to cover only 2 percent of the target population to provide a third-cousin match to nearly any person.[47] The authors of the study noted that genetic information and the use of genetic databases that are publicly available could be used for harmful purposes, such as re-identifying research subjects from their genetic data.

Chief Financial Officer Jimmy Patronis issued a consumer alert on August 15, 2019, warning Floridians of genetic testing scams that purport to offer free genetic testing to Medicare beneficiaries, but are actually attempts to obtain personal information for identity theft or Medicare information for fraudulent billing purposes.[48] The consumer alert noted that the Better Business Bureau had started receiving reports of the genetic testing scams, which occurred through telemarketing calls, booths at public events, health fairs, and door-to-door visits.[49]

A Department of Defense memorandum issued December 20, 2019, advised military personnel to refrain from the purchase or use of direct-to-consumer genetic testing. The department noted that direct-to-consumer genetic tests "are largely unregulated and could expose personal and genetic information, and potentially create unintended security consequences and increased risk

[45] Federal Trade Commission, *DNA Test Kits: Consider the Privacy Implications*, (December 12, 2017). https://www.consumer.ftc.gov/blog/2017/12/dna-test-kits-consider-privacy-implications (last accessed January 24, 2020).
[46] Jocelyn Kaiser, *We Will Find You: DNA Search Used to Nab Golden State Killer Can Home In On About 60% of White Americans*, Science (October 11, 2018) https://www.sciencemag.org/news/2018/10/we-will-find-you-dna-search-used-nab-golden-state-killer-can-home-about-60-white (last accessed January 27, 2020).
[47] Yaniv Erlich et al., *Identify Inference of Genomic Data Using Long-Range Familial Searches*, Science Vol. 362, Issues 6415, Pgs. 690-694 (November 9, 2018) https://science.sciencemag.org/content/362/6415/690/tab-pdf (last accessed January 27, 2020).
[48] Florida Department of Financial Services, *Consumer Alert CFO Jimmy Patronis: Beware of Door to Door Genetic Testing Scams Targeting Seniors*, (August 15, 2019) https://www.myfloridacfo.com/sitePages/newsroom/pressRelease.aspx?ID=5357 (last accessed January 27, 2020).
[49] Better Business Bureau, *BBB Warning: Beware of Genetic Testing Scam Hitting Florida*, (August 2, 2019). https://www.bbb.org/article/news-releases/20457-bbb-warning-beware-of-genetic-testing-scam-hitting-florida (last accessed January 27, 2020).

to the joint force and mission."[50] The memorandum stated that many direct-to-consumer genetic tests that provide health information vary in their validity and are not reviewed by the Food and Drug Administration, and thus are not independently reviewed to verify the claims of the seller.[51] The memorandum also noted that "there is increased concern in the scientific community that outside parties are exploiting the use of genetic data for questionable purposes, including mass surveillance and the ability to track individuals without their authorization or awareness."[52]

Life Insurance, Disability Insurance, and Long-Term Care Insurance

Forms of Life Insurance

Life insurance is the insurance of human lives.[53] Life insurance can be purchased in the following forms:[54]

- Term life insurance provides coverage for a set term of years and pays a death benefit if the insured dies during the term.[55]
- Permanent life insurance remains in place if the insured pays premiums, and the coverage pays a death benefit. Such policies have an actual cash value component that increases over time and from which the policy owner may borrow. There are four types of permanent life insurance:
  - Whole life insurance offers a fixed premium, guaranteed annual cash value growth and a guaranteed death benefit. It does not provide investment flexibility and the policy coverage, once established, may not be changed.
  - Universal life insurance allows the policyholder to determine the amount and timing of premium payments within certain limits. The coverage level may be adjusted. It guarantees certain levels of annual cash value growth but not investment flexibility.
  - Variable life insurance allows allocation of investment funds, but does not guarantee minimum cash value because of fluctuations in the value of investments.
  - Variable universal life insurance combines variable and universal life insurance.[56]

Life Insurance Underwriting and Risk Classification

Life insurance underwriters seek to identify and classify the risk represented by a proposed insured and then classify those risks into pools of similar mortality or morbidity risk.[57] Mortality risk the risk of death whereas morbidity risk is the risk of being unhealthy or having a disease. Insureds within the same risk classification pay the same premiums, which must be adequate to ensure solvency, pay claims, and provide the insurer (with investment income) a reasonable rate

---

[50] Department of Defense, *Memorandum on Direct-to-Consumer Genetic Testing Advisory for Military Members*, (Dec 20, 2019) https://www.scribd.com/document/440727436/DOD-memo-on-DNA-testing#download&from_embed (last accessed January 27, 2019).
[51] *See id*.
[52] *See id*.
[53] Section 624.602, F.S.
[54] National Association of Insurance Commissioners, *Life Insurance – Considerations for All Life Situations*, http://www.insureuonline.org/insureu_type_life.htm (last accessed January 24, 2020).
[55] National Association of Insurance Commissioners, *Life Insurance FAQs*, http://www.insureuonline.org/consumer_life_faqs.htm (last accessed January 24, 2020).
[56] *See* "What are the different types of permanent life insurance policies?" *available at* https://www.iii.org/article/what-are-different-types-permanent-life-insurance-policies (last accessed March 26, 2019).
[57] American Council of Life Insurers, *Life Insurer Issues*. (On file with the Senate Committee on Banking and Insurance).

of return. Accurate risk assessment is important in life insurance because misclassification of risk results in severe consequences because the life insurance contract is often in place for long periods of time, as in the case of long-term and whole life policies.[58]

A 2019 paper in the Journal of Insurance Regulation of the National Association of Insurance Commissioners noted that more than 5,000 genes have been identified as relating to a particular disease, many of which have predictive value in estimating the probability in developing a genetic disease that has consequences for mortality.[59] Examples of genetic tests with informational value for life insurance underwriting include:

- Breast cancer – BRCA1 or BRCA 2;
- Hypertrophic cardiomyopathy;
- Dilated cardiomyopathy;
- Arrhythmogenic right ventricular cardiomyopathy;
- Long QT syndrome;
- Brugada syndrome;
- Huntington's disease;
- Polycystic kidney disease;
- Myotonic muscular dystrophy – DM1 or DM2;
- Alzheimer's disease early onset, autosomal dominance;
- Hereditary nonpolyposis colorectal cancer;
- Marfan Syndrome; and
- Catecholaminergic polymorphic ventricular tachycardia.

When a policyholder has access to information about their mortality risk that the life insurer lacks, two problems arise for the life insurer. The first problem is that the policy may be underpriced, which can result in inadequate premium dollars to pay death benefits.[60] The second problem is that consumers with knowledge of their increased mortality risk will be more likely to keep their policy in-force, which also has an impact on proper pricing of life insurance as premiums are calculated using assumptions that a certain percentage of policyholders will allow the insurance contract to lapse.[61]

The American Council of Life Insurers has expressed concerns that the proliferation of genetic testing could increase adverse selection and impact the availability and affordability of products over time.[62] Studies addressing whether genetic testing leads to adverse selection have reached varying conclusions. Studies of women tested for the BRCA1 gene mutation (linked to breast

[58] Patricia Born, *Genetic Testing in Underwriting: Implications for Life Insurance Markets, Journal of Insurance Regulation* Vol. 38, No. 5 (2019) https://www.naic.org/prod_serv/JIR-ZA-38-05-EL.pdf (last accessed January 27, 2020).
[59] *See* Born fn. 58 at pg. 5.
[60] *See* Born fn. 58 at pg. 10.
[61] *See id*.
[62] Gina Kolata, *New Gene Tests Pose a Threat to Insurers*, New York Times (May 12, 2017) https://www.nytimes.com/2017/05/12/health/new-gene-tests-pose-a-threat-to-insurers.html (last accessed January 24, 2020).

cancer risk)[63] and adults tested for Alzheimer's risk[64] found little evidence of adverse selection in the life insurance market. However, the study regarding Alzheimer's risk found evidence of adverse selection for long-term care insurance, as 17 percent of those who tested positive subsequently changed their LTC policy in the year after testing positive of Alzheimer's risk, in comparison with 2 percent of those who tested negative and 4 percent of those who did not receive test results.[65]

Annuities

Life insurance also encompasses annuities and disability policies.[66] An annuity is a contract between a customer and an insurer wherein the customer makes a lump-sum payment or a series of payments to an insurer that in return agrees to make periodic payments to the annuitant at a future date, either for the annuitant's life or a specified period. Disability insurance pays a weekly or monthly income for a set period if the insured becomes disabled and cannot continue working or obtain work.

Disability Insurance

Disability insurance compensates the insured for a portion of income lost because of a disabling injury or illness.[67] There are two types of disability insurance: short-term and long-term. A short-term policy typically replaces a portion of lost income from 3 to 6 months following the disability. Long-term policies generally begin 6 months after the disability and can last a set number of years or until retirement age. Disability insurance is sometimes offered by life insurers.

Long-Term Care Insurance

Long-term care (LTC) insurance covers the costs of nursing homes, assisted living, home health care, and other long-term care services. A long-term care insurance policy provides coverage for medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital.[68] Long-term care insurance usually pays fixed-dollar amounts or the actual costs of care, often subject to a maximum daily benefit amount.[69]

---

[63] Cathleen D. Zick, et. al., *Genetic Testing, Adverse Selection, and the Demand for Life Insurance*, pgs. 29-39 American Journal of Medical Genetics (July 2000) (Abstract provided by NIH at https://www.ncbi.nlm.nih.gov/pubmed/10861679 (last accessed January 24, 2020)).
[64] Cathleen D. Zick, *Genetic Testing For Alzheimer's Disease And Its Impact on Insurance Purchasing Behavior*, pgs. 483-490, Health Affairs vol. 23, no. 2 (March/April 2005) https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.483 (last accessed January 24, 2020).
[65] *See* Zick fn. 64 at pgs. 487-488.
[66] Section 624.602, F.S.
[67] *See* National Association of Insurance Commissioners, *A Worker's Most Valuable Asset: Protecting Your Financial Future with Disability Insurance*
http://www.naic.org/documents/consumer_alert_protecting_financial_future_disability_insurance.htm (last accessed January 24, 2020).
[68] Section 627.9404(1), F.S.
[69] Florida Department of Financial Services, *Long-Term Care: A Guide for Consumers*, pg. 5.
https://www.myfloridacfo.com/division/consumers/UnderstandingCoverage/Guides/documents/LTCGuide.pdf (last accessed January 24, 2020).

The LTC insurance market provides an example of the negative effects of insurers not accurately projecting their underwriting risk. LTC insurers made incorrect assumptions when selling the coverage, particularly in the 1980s and 1990s.[70] The LTC insurers overestimated the number of people that would cancel their coverage or allow it to lapse, underestimated the life span of insureds and the time span of the treatment they would receive, and overestimated earnings on LTC premiums which were negatively affected by dropping interest rates.[71] As a result, long-term care insurance premiums have been rising, often substantially, for the past decade.[72]

In response to substantial LTC premium increases, Florida law prohibits LTC rate increases that would result in a premium in excess of that charged on a newly issued policy, except to reflect benefit differences.[73] If the insurer is not writing new LTC policies, the rate cannot exceed the new business rate of insurers representing 80 percent of the carriers in the marketplace. In January 2017, the OIR issued consent orders allowing two of the state's largest LTC insurers, Metropolitan Life Insurance Company and Unum Life Insurance Company of America, to substantially raise LTC monthly premiums, phased in over 3 years.[74] Many insurers that write LTC insurance have taken substantial losses. In January 2018, General Electric announced a $6.2 billion charge against earnings and a $15 billion shortfall in insurance reserves related to LTC insurance obligations.[75]

Prohibition of Unfair Discrimination Between Individuals

Insurance policy forms for insurance sold in Florida must be filed and approved by the Office of Insurance Regulation (OIR).[76] The Unfair Insurance Trade Practices Act prohibits "knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class and expectation of life, in the rates charged for a life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other term or condition of such contract."[77] Similarly, the act prohibits knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class, as determined at the time of initial issuance of the coverage, and essentially the same hazard, in the amount of

[70] *See* Leslie Scism, *Millions Bought Insurance to Cover Retirement Health Costs. Now They Face an Awful Choice,* Wall Street Journal (January 17, 2018) https://www.wsj.com/articles/millions-bought-insurance-to-cover-retirement-health-costs-now-they-face-an-awful-choice-1516206708 (last accessed January 24, 2020).
[71] *See* Office of Insurance Regulation, *Long-Term Care Public Rate Hearings*. (The Internet page references a rate filing decision made by the OIR on Jan. 12, 2017, related to LTC products for two insurers). https://www.floir.com/Sections/LandH/LongTermCareHearing.aspx (last accessed January 24, 2020); *See* Scism at fn. 70.
[72] *See* Scism at fn. 70; See Office of Insurance Regulation at fn. 71. https://www.floir.com/Sections/LandH/LongTermCareHearing.aspx (last accessed January 24, 2020).
[73] Section 627.9407(7)(c), F.S.
[74] *See* Office of Insurance Regulation, *Consent Order In the Matter of: Metropolitan Life Insurance Company*, Case No. 200646-16-CO (Jan. 12, 2017) https://www.floir.com/siteDocuments/MetLife200646-16-CO.pdf (last accessed January 24, 2020); Office of Insurance Regulation, *Consent Order In The Matter of Unum Life Insurance Company of America*, Case No. 200879-16-CO (Jan. 12, 2017) https://www.floir.com/siteDocuments/Unum200879-16-CO.pdf (last accessed January 24, 2020).
[75] Sonali Basak, Katherine Chiglinsky, et al, *GE's Surprise $15 Billion Shortfall Was 14 Years in the Making*, Chicago Tribune, (January 25, 2018) http://www.chicagotribune.com/business/ct-biz-ge-general-electric-accounting-20180125-story.html (last accessed January 24, 2020); Steve Lohr and Chad Bray, *At G.E., $6.2 Billion Charge for Finance Unit Hurts C.E.O.'s Turnaround Push*, New York Times, (January 16, 2018). https://www.nytimes.com/2018/01/16/business/dealbook/general-electric-ge-capital.html (last accessed January 24, 2020).
[76] Section 624.410, F.S.
[77] Section 626.9541(1)(g)1., F.S.

premium, policy fees, or rates charged for a policy or contract of disability insurance, in benefits payable, in the terms or conditions of the contract, or in any other manner.[78]

III. Effect of Proposed Changes:

Section 1 amends s. 627.4301, F.S., to provide criteria that must be met for a life insurer, long-term care insurer, or disability income insurer to use genetic information, including the results of direct-to-consumer genetic testing, for underwriting purposes. The criteria are:

- The genetic information is contained in the medical record;
- The use of genetic testing results is limited to what is in the medical record;
- The genetic information is relevant to a potential medical condition that impacts mortality or morbidity risk; and
- The genetic information is related to expected mortality or morbidity based on sound actuarial principles or reasonably expected experience.

The bill prohibits a life insurer, long-term care insurer, or disability income insurer from cancelling coverage based solely on genetic information. Florida law currently provides that life insurance and long-term care insurance policies are incontestable and may not be cancelled except for nonpayment of premium after 2 years in force.[79] For life insurance and long-term care insurance contracts, the prohibition on cancellations based solely on genetic information would only be relevant during the first 2 years the contract is in force. The prohibition would be relevant throughout the time a disability income policy is in-force because provisions in an insurance policy relating to disability benefits may, at the option of the insurer, be exempt from the 2-year incontestability period.

The bill prohibits a life insurer, long-term care insurer, or disability income insurer from requiring an applicant take a genetic test as a condition of insurability, and prohibits such insurers from obtaining, requesting, or otherwise requiring the complete genome sequence of an applicant's DNA.

The bill defines:

- "Life insurer" to have the same meaning as provided in s. 624.602, F.S.;[80] and to include an insurer issuing life insurance contracts that grant additional benefits in the event of an insured's disability;
- "Long-term care insurer" as an insurer issuing long-term care insurance policies as described in s. 627.9404, F.S.[81]

[78] Section 626.9541(1)(g)2., F.S.
[79] *See* ss. 627.455, F.S., and 627.94076, F.S.
[80] Section 624.602, F.S., defines a life insurer as an insurer engaged in the business of issuing life insurance contracts, including contracts of combined life and health and accident insurance. Life insurance is defined as the insurance of human lives, transactions of which include annuity contracts, granting endowment benefits, providing additional benefits in the event of death or dismemberment by accident or accidental means, additional benefits in the event of the insured's disability.
[81] Section 627.9404, F.S., defines a long-term care insurance policy to mean any insurance policy or rider advertised, marketed, offered, or designed to provide coverage on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital. The definition specifies various coverages that are not long-term care insurance such as Medicare supplement coverage, disability income coverage, and others.

The bill amends the definition of "genetic information" to include the results of direct-to-consumer genetic testing. This explicitly applies the existing prohibition against health insurers using genetic information in the absence of a diagnosis to direct-to-consumer genetic testing. The inclusion of direct-to-consumer genetic testing results within the definition of genetic information means that under this bill, life insurers, long-term care insurers, and disability income insurers may only use direct-to-consumer genetic testing for underwriting purposes if such testing is contained in the medical record and relevant to a medical condition impacting mortality or morbidity risk based on sound actuarial principles.

Section 2 amends s. 760.40, F.S., to require companies that provide direct-to-consumer genetic testing must obtain written consent from the consumer prior to sharing genetic information or personally identifiable information about a consumer with a life insurer or health insurer.

Section 3 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill provides that a life insurer, long-term care insurer, or disability income insurer may only use genetic information if certain criteria are met. These criteria include, on lines 54-55, that "the genetic information is relevant to a *potential* medical condition that impacts mortality or morbidity risk." This appears to unintentionally allow use of genetic information when relevant to a potential medical condition, but not when relevant to an actual medical condition.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 627.4301 and 760.40 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 28, 2020:
The CS provides conditions under which life insurers, long-term care insurers, and disability income insurers may use genetic information, including direct-to-consumer genetic testing, in underwriting. The CS requires companies that provide direct-to-consumer genetic testing must obtain written consent from the consumer prior to sharing genetic information or personally identifiable information about a consumer with a life insurer or health insurer.

Previously, the bill prohibited such insurers from using genetic information to cancel, limit, or deny coverage, or establish differentials in premium rates, nor could such insurers require or solicit genetic information, use genetic test results, or consider a person's decisions regarding genetic testing in any manner for any insurance purpose.

B. Amendments:

None.

208866

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/28/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 627.4301, Florida Statutes, is amended to read:

627.4301 Genetic information for insurance purposes.—

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

(a) "Genetic information" means information derived from genetic testing to determine the presence or absence of

208866

variations or mutations, including carrier status, in an individual's genetic material or genes that are scientifically or medically believed to cause a disease, disorder, or syndrome, or are associated with a statistically increased risk of developing a disease, disorder, or syndrome, which is asymptomatic at the time of testing. Such testing does not include routine physical examinations or chemical, blood, or urine analysis, unless conducted purposefully to obtain genetic information, or questions regarding family history. Genetic information includes the results of direct-to-consumer commercial genetic testing.

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a self-insured plan as defined in s. 624.031, a multiple-employer welfare arrangement as defined in s. 624.437, a prepaid limited health service organization as defined in s. 636.003, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, a fraternal benefit society as defined in s. 632.601, or any health care arrangement whereby risk is assumed.

(c) "Life insurer" has the same meaning as provided in s. 624.602 and includes an insurer issuing life insurance contracts that grant additional benefits in the event of the insured's disability.

(d) "Long-term care insurer" means an insurer that issues long-term care insurance policies as defined in s. 627.9404.

(2) USE OF GENETIC INFORMATION.—

(a) In the absence of a diagnosis of a condition related to genetic information, no health insurer authorized to transact

208866

insurance in this state may cancel, limit, or deny coverage, or establish differentials in premium rates, based on such information.

(b) Health insurers may not require or solicit genetic information, use genetic test results, or consider a person's decisions or actions relating to genetic testing in any manner for any insurance purpose.

(c) A life insurer, long-term care insurer, or disability income insurer may use genetic information for underwriting purposes only if all of the following criteria are met:

1. The genetic information is contained in the medical record.

2. The use of any genetic testing results is limited to what is in the medical record.

3. The genetic information is relevant to a potential medical condition that impacts mortality or morbidity risk.

4. The genetic information is related to expected mortality or morbidity based on sound actuarial principles or reasonably expected experience.

(d) A life insurer, long-term care insurer, or disability income insurer may not:

1. Cancel coverage based solely on genetic information;

2. Require an applicant to take a genetic test as a condition of insurability; or

3. Obtain, request, or otherwise require the complete genome sequence of an applicant's DNA.

(e) This section does not apply to the underwriting or issuance of an ~~a life insurance policy, disability income policy, long-term care policy,~~ accident-only policy, a hospital

208866

indemnity or fixed indemnity policy, a dental policy, or a vision policy or any other actions of an insurer directly related to an ~~a life insurance policy, disability income policy, long-term care policy,~~ accident-only policy, a hospital indemnity or fixed indemnity policy, a dental policy, or a vision policy.

Section 2. Subsection (4) is added to section 760.40, Florida Statutes, to read:

760.40 Genetic testing; informed consent; confidentiality; penalties; notice of use of results.—

(4) A company providing direct-to-consumer commercial genetic testing may not share any genetic information or personally identifiable information about a consumer with a life insurer or health insurer unless the company obtains prior written consent from the consumer.

Section 3. This act shall take effect July 1, 2020.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the use of genetic information; amending s. 627.4301, F.S.; revising the definition of the term "genetic information"; defining the terms "life insurer" and "long-term care insurer"; specifying criteria that must be met before a life insurer, long-term care insurer, or disability income insurer may use genetic information for underwriting

208866

purposes; specifying prohibited acts by such insurers relating to genetic information; amending s. 760.40, F.S.; prohibiting companies providing direct-to-consumer commercial genetic testing from sharing certain information about a consumer with a life insurer or health insurer unless the company obtains the consumer’s prior written consent; providing an effective date.

By Senator Stargel

22-01738A-20 20201564__

A bill to be entitled

An act relating to genetic information for insurance purposes; amending s. 627.4301, F.S.; providing definitions; prohibiting life insurers and long-term care insurers from canceling, limiting, or denying coverage, or establishing differentials in premium rates, based on genetic information under certain circumstances; prohibiting such insurers from taking certain actions relating to genetic information for any insurance purpose; providing applicability; providing an effective date.

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

Section 1. Section 627.4301, Florida Statutes, is amended to read:

627.4301 Genetic information for insurance purposes.—

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

(a) "Genetic information" means information derived from genetic testing to determine the presence or absence of variations or mutations, including carrier status, in an individual's genetic material or genes that are scientifically or medically believed to cause a disease, disorder, or syndrome, or are associated with a statistically increased risk of developing a disease, disorder, or syndrome, which is asymptomatic at the time of testing. Such testing does not include routine physical examinations or chemical, blood, or urine analysis, unless conducted purposefully to obtain genetic information, or questions regarding family history.

22-01738A-20 20201564__

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a self-insured plan as defined in s. 624.031, a multiple-employer welfare arrangement as defined in s. 624.437, a prepaid limited health service organization as defined in s. 636.003, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, a fraternal benefit society as defined in s. 632.601, or any health care arrangement whereby risk is assumed.

(c) "Life insurer" has the same meaning as in s. 624.602 and includes an insurer issuing life insurance contracts that grant additional benefits in the event of the insured's disability.

(d) "Long-term care insurer" means an insurer that issues long-term care insurance policies as described in s. 627.9404.

(2) USE OF GENETIC INFORMATION.—

(a) In the absence of a diagnosis of a condition related to genetic information, ~~no~~ health insurers, life insurers, and long-term care insurers ~~insurer~~ authorized to transact insurance in this state may not cancel, limit, or deny coverage, or establish differentials in premium rates, based on such information.

(b) Health insurers, life insurers, and long-term care insurers may not require or solicit genetic information, use genetic test results, or consider a person's decisions or actions relating to genetic testing in any manner for any insurance purpose.

(c) This section does not apply to the underwriting or issuance of an ~~a life insurance policy, disability income~~

~~policy, long-term care policy,~~ accident-only policy, hospital indemnity or fixed indemnity policy, dental policy, or vision policy or any other actions of an insurer directly related to an ~~a life insurance policy, disability income policy, long-term care policy,~~ accident-only policy, hospital indemnity or fixed indemnity policy, dental policy, or vision policy.

Section 2. This act applies to policies entered into or renewed on or after January 1, 2021.

Section 3. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28
Meeting Date

1564
Bill Number (if applicable)

Topic Genetic Information for Insurance Purposes

Amendment Barcode (if applicable)

Name Chase Mitchell

Job Title Sr. Management Analyst

Address PL 17, The Capitol
Street

Phone (850) 413-2866

Tallahassee FL 32399
City *State* *Zip*

Email Chase.Mitchell@myfloridacfo.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing CFO Jimmy Patronis

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28
Meeting Date

1564
Bill Number (if applicable)

Topic Genetic Information for Insurance purposes

Amendment Barcode (if applicable)

Name Katie Flury

Job Title Government Consultant

Address 301 E. Pine St.
Street

Phone

Orlando FL 32801
City *State* *Zip*

Email Katie.Flury@gray-robinson.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing UF Health Shands

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

412K 4-6

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/28/20
Meeting Date

1564
Bill Number (if applicable)

Topic GENETIC INFORMATION

Amendment Barcode (if applicable)

Name Sal Nuzzo

Job Title Vice President of Policy

Address 100 N Duval Street
Street

Phone 850-322-9941

Tallahassee FL 32301
City *State* *Zip*

Email snuzzo@jamesmadison.org

Speaking: ☐ For ☒ Against ☐ Information

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

Representing The James Madison Institute

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/2020
Meeting Date

SB 1564
Bill Number (if applicable)

Topic Genetic Testing

Amendment Barcode (if applicable)

Name Pierce Schuessler

Job Title

Address 119 South Monroe Street
Street

Phone 8502059000

Tallahassee fl 32312
City *State* *Zip*

Email pierce.schuessler@mhdfirm.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Bio Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Jan 28
Meeting Date

1564
Bill Number (if applicable)

208866
Amendment Barcode (if applicable)

Topic _____

Name Tim Meenan

Job Title _____

Address 300 S. Duval Street
Street

Phone (850) 425-4000

_____
City *State* *Zip*

Email _____

Speaking: ☒ For ☐ Against ☐ Information

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

Representing National Association of Insurance & Financial Advisors

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

01/28/2020
Meeting Date

S 1564
Bill Number (if applicable)

268866
Amendment Barcode (if applicable)

Topic Life Insurance Underwriting

Name Robert Gleason

Job Title Medical Consultant American Council Life Insurance

Address 9705 N. Lake Dr. Phone 414. 331. 7462
Street

Milwaukee WI 53217 Email dubobgleason@wkn.com
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-28-2020
Meeting Date

SB 1564
Bill Number (if applicable)

208866
Amendment Barcode (if applicable)

Topic Genetic Testing

Name Joy Ryan

Job Title

Address 300 S. Duval St., #410
Street

Tally
City *State* *Zip*

Phone 425-4000

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Insurance Council ↳ of amendment

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1672
INTRODUCER:	Senator Broxson
SUBJECT:	Protection of Vulnerable Investors
DATE:	January 27, 2020
REVISED:	1/28/2020

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

I. Summary:

SB 1672 provides additional protections for investors who are specified adults (age 65 years or older) or vulnerable adults who may be victims of suspected financial exploitation. A vulnerable adult is a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. In Florida an estimated 20 percent (or 4,129,854) of the population is age 65 or older.[1] Studies show that financial exploitation is the most common form of elder abuse and yet few incidents are reported. Estimates of annual losses to older adults have ranged from $2.9 billion to $36.5 billion in the United States.

The bill explicitly requires securities dealers, investment advisers, and associated persons to report knowledge or suspicion of abuse, neglect, or exploitation of vulnerable adults to the Department of Children and Families' central abuse hotline immediately. Current law requires *any person* who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited to report suspected abuse to the central abuse hotline immediately. The bill also allows securities dealers and investment advisers to delay disbursements or transaction of funds or securities from an account of a specified adult or a vulnerable adult if the following conditions apply:

- The dealer or investment adviser reasonably believes that financial exploitation of the specified adult has occurred, is occurring, has been attempted, or will be attempted in connection with the disbursement or transaction.
- No later than 3 business days after the date on which the delay was first placed, the dealer or investment adviser provides written notification to all parties authorized to transact business on the account and any trusted contact on the account, using the contact information provided

[1] Department of Elder Affairs, *Profile of Older Floridians, 2018 Projections* at http://elderaffairs.state.fl.us/doea/pubs/stats/County_2018_projections/Counties/Florida.pdf (last viewed Jan. 23, 2020).

on the account, unless the dealer or investment adviser believes that any of the parties are involved in the suspected exploitation. The notice must provide the reason for the delay.

- No later than 3 business days after the date on which the delay was first placed, the dealer or investment adviser notifies the Office of Financial Regulation (OFR) of the delay by telephone using a number designated by the OFR for such purpose or electronically on a form prescribed by commission rule. The notice must identify the dealer or investment adviser that made the delay, the name of the person who authorized the delay, and the date on which the delay was made.
- The dealer or investment adviser immediately initiates an internal review of the facts and circumstances that caused the dealer or investment adviser to reasonably believe that the financial exploitation of the specified adult has occurred, is occurring, has been attempted, or will be attempted.

A delay in disbursement or transaction of funds or securities expires in 15 business days, and may be extended for an additional 10 business days. A court of competent jurisdiction may shorten or extend the length of any delay.

The bill grants immunity from any administrative or civil liability that might otherwise arise from a delay in a disbursement or transaction to any dealer, investment adviser, or associated person who in good faith and exercising reasonable care complies with the provisions of s. 517.34, F.S. The bill does not alter the obligation of a dealer, investment adviser, or associated person to comply with instructions from a client absent a reasonable belief of financial exploitation.

The bill does not create new rights or obligations of a dealer, investment adviser, or associated person under other applicable laws or rules. The bill does not limit the right of a dealer, investment adviser, or associated person to refuse to place a delay on a transaction or disbursement under other laws or rules or under a customer agreement

The bill has indeterminate fiscal impact on the Office of Financial Regulation.

II. Present Situation:

In Florida an estimated 20 percent (or 4,129,854) of the population is age 65 or older.[2] Since 2013, financial institutions have reported to the federal government over 180,000 suspicious activities targeting older adults, involving a total of more than $6 billion. These reports indicate that financial exploitation of older adults by scammers, family members, caregivers, and others is widespread in the United States.[3] Studies show that financial exploitation is the most common form of elder abuse and yet few incidents are reported.[4] Estimates of annual losses to older adults have ranged from $2.9 billion to $36.5 billion.[5]

[2] Department of Elder Affairs, *Profile of Older Floridians, 2018 Projections* at http://elderaffairs.state.fl.us/doea/pubs/stats/County_2018_projections/Counties/Florida.pdf (last viewed Jan. 23, 2020).
[3] Consumer Financial Protection Bureau, *Suspicious Activity Reports on Elder Financial Exploitation: Issues and Trends* (Feb. 2019) at https://files.consumerfinance.gov/f/documents/cfpb_suspicious-activity-reports-elder-financial-exploitation_report.pdf (last viewed Jan. 18, 2020).
[4] *Id.*
[5] *Id.*

Financial exploitation occurs when a person misuses or takes the assets of a vulnerable adult for his or her own personal benefit. This frequently occurs without the knowledge or consent of a senior or disabled adult, depriving him or her of financial resources for personal needs. Assets are taken commonly by deception, false pretenses, coercion, harassment, duress and threats. The following is a list of commonly reported forms of financial exploitation reported to adult protective services in the United States:[6]

- Investment - includes investments made without knowledge or consent and may include high-fee funds (front or back-loaded) or excessive trading activity to generate commissions for financial advisors.
- Theft - involves taking assets without knowledge, consent or authorization and may include taking of cash, valuables, medications, or other personal property.
- Fraud - involves acts of dishonesty by persons entrusted to manage assets and may include falsification of records, forgeries, unauthorized check-writing, and Ponzi-type financial schemes.
- Real Estate - involves unauthorized sales, transfers or changes to property, and may include unauthorized or invalid changes to estate documents.
- Contractor - includes building contractors who receive payment for building repairs, but fail to initiate or complete the project and may include invalid liens by contractors.
- Lottery scams - involves payments to collect unclaimed property or "prizes" from lotteries or sweepstakes.
- Electronic - includes "phishing" e-mail messages to trick persons into unwittingly surrendering bank passwords and may include faxes, wire transfers, telephonic communications.
- Mortgage - includes financial products, which are unaffordable or out-of-compliance with regulatory requirements and may include loans issued against property by unauthorized parties.
- Insurance - involves sales of inappropriate products, such as a 30-year annuity for an elderly person and may include unauthorized trading of life insurance policies.

Social isolation and mental impairment have been identified as two factors that make older adults vulnerable to abuse. Recent studies show that nearly half of those with dementia experienced abuse or neglect. Interpersonal violence also occurs at disproportionately higher rates among adults with disabilities.[7]

Mandatory Reporting for Abuse or Exploitation of Vulnerable Adults in Florida

The Adult Protective Services Act (ch. 415, F.S.) defines abuse as any willful act or threatened act by a relative, caregiver, or household member, which harms or is likely to harm a vulnerable adult's physical, mental, or emotional health.[8] The Adult Protective Services program is located within the Department of Children and Families, and is responsible for investigating allegations

[6] National Adult Protective Services Association website, see http://www.napsa-now.org/get-informed/what-is-financial-exploitation/ (last viewed Jan. 20, 2020). Definitions of financial exploitation vary from jurisdiction to jurisdiction.
[7] National Council on Aging, *Elder Abuse Facts*, at https://www.ncoa.org/public-policy-action/elder-justice/elder-abuse-facts/ (last viewed Jan. 23, 2020).
[8] Section 415.102, F.S.

of abuse, neglect or exploitation, as provided in the Adult Protective Services Act.[9] Section 415.1034, F.S., requires any person who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited to report suspected abuse to the central abuse hotline immediately. Any person reporting or that participates in a judicial proceeding is presumed to be acting in good faith and, unless lack of good faith is shown by clear and convincing evidence, is immune from any civil or criminal liability that otherwise might be incurred or imposed.[10]

For purposes of the Adult Protective Services Act, the following terms apply:

- A "vulnerable adult" is a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.[11]
- "Exploitation" means a person who:[12]
  - Stands in a position of trust and confidence with a vulnerable adult and knowingly, by deception or intimidation, obtains or uses, or endeavors to obtain or use, a vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive a vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult; or
  - Knows or should know that the vulnerable adult lacks the capacity to consent, and obtains or uses, or endeavors to obtain or use, the vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the vulnerable adult of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the vulnerable adult.
- "Exploitation" may include, but is not limited to:[13]
  - Breaches of fiduciary relationships, such as the misuse of a power of attorney or the abuse of guardianship duties, resulting in the unauthorized appropriation, sale, or transfer of property;
  - Unauthorized taking of personal assets;
  - Misappropriation, misuse, or transfer of moneys belonging to a vulnerable adult from a personal or joint account; or
  - Intentional or negligent failure to effectively use a vulnerable adult's income and assets for the necessities required for that person's support and maintenance.

Once a person reports to the central abuse hotline, the department must initiate a protective investigation within 24 hours.[14] If a caregiver refuses to allow the department to begin a protective investigation or interferes with the investigation, the department can contact the appropriate law enforcement agency for assistance. If, during the course of the investigation, the department has reason to believe that the abuse, neglect, or exploitation is perpetrated by a second party, the appropriate law enforcement agency and state attorney must be notified. The

[9] Sections 415.101-415.113, F.S.
[10] Section 415.1036, F.S.
[11] *See* s. 415.102(28), F.S.
[12] *See* s. 415.102(8), F.S.
[13] *Id.*
[14] Section 415.104, F.S.

department shall make a preliminary written report to the law enforcement agencies within 5 working days after the oral report and complete the investigation within 60 days.[15]

Regulation of Securities

Federal Oversight

The Securities and Exchange Commission (SEC), created by the federal Securities Act of 1934 ('34 Act), has broad authority over all aspects of the securities industry, including the power to register, regulate, and oversee broker-dealers, brokerage firms, transfer agents, and clearing agencies, as well as the nation's securities self-regulatory organizations (SROs). [16] The '34 Act broadly defined "broker" as "any person engaged in the business of effecting transactions in securities for the account of others," which the SEC has interpreted to persons involved in any of the key aspects of a securities transaction, such as solicitation, negotiation, and execution.[17] A "dealer" is "any person engaged in the business of buying and selling securities… for such person's own account through a broker or otherwise."[18] In addition to being registered with the SEC, broker-dealers must comply with state registration requirements.

The Financial Industry Regulatory Authority (FINRA) is a SRO. Most broker-dealers in the United States are members of FINRA. As members, such broker-dealers are subject to FINRA rules and examination by FINRA. In an effort to address financial exploitation of seniors, FINRA implemented rules to provide a safe harbor for a FINRA member to place temporary holds on disbursements of funds or securities held in accounts of specified adults where there is a reasonable belief of financial exploitation of these customers is occurring, has been attempted, or will be attempted.[19]

The FINRA Rule 2165[20] defines a specified adult as:

- A natural person age 65 and older; or
- A natural person age 18 and older who the member reasonably believes has a mental or physical impairment that renders the individual unable to protect his or her own interests.[21]

Further, the rule defines the term, "financial exploitation" to mean:

---

[15] *Id.*

[16] 15 U.S.C. ss. 78c(4) and 78o; U.S. SECURITIES AND EXCHANGE COMMISSION, *Guide to Broker-Dealer Registration*, http://www.sec.gov/divisions/marketreg/bdguide.htm#II (last visited Feb. 19, 2018).

[17] *Id.*

[18] 15 U.S.C. s. 78c(5). Certain entities in the securities industry are referred to as "broker-dealers" because the institution is a "broker" when executing trades on behalf of a customer, but is a "dealer" when executing trades for its own account.

[19] *See* Supplementary Material, Rule 2165.01, *Applicability of Rule.* This rule provides members and their associated persons with a safe harbor from FINRA Rules 2010, 2150, and 11870 when members exercise discretion in placing temporary holds on disbursements of funds or securities from the accounts of specified adults consistent with the requirements of this rule. This rule does not require members to place temporary holds on disbursements of funds or securities from the accounts of specified adults. See also Rule 4512, *Customer Account Information*.

[20] FINRA, Financial Exploitation of Specified Adults, Rule 2165, at http://finra.complinet.com/en/display/display_main.html?rbid=2403&element_id=12784 and FINRA, Frequently Asked Questions Regarding FINRA Rules Relating to Financial Exploitation of Seniors, available at http://www.finra.org/industry/frequently-asked-questions-regarding-finra-rules-relating-financial-exploitation-seniors (last viewed Jan. 19, 2020).

[21] *Id.*

- The wrongful or unauthorized taking, withholding, appropriation, or use of a specified adult's funds or securities; or
- Any act or omission by a person, including through the use of a power of attorney, guardianship, or any other authority regarding a specified adult, to:
  - Obtain control, through deception, intimidation or undue influence, over the Specified Adult's money, assets or property; or
  - Convert the specified adult's money, assets or property.[22]

The rules provide that a FINRA member has the ability to contact a customer's designated trusted contact person and, when appropriate, place a temporary hold on a disbursement of funds or securities from a customer's account.[23] The temporary hold expires after 15 business days, but the FINRA member may extend the hold by up to an additional 10 business days if the member's internal review of facts and circumstances supports its reasonable belief that the financial exploitation has occurred, is occurring, has been attempted, or will be attempted.[24] Rule 2165 became effective February 5, 2018. However, the rule does not apply to broker-dealers and investment advisers who are not members of FINRA.

Florida Oversight

In addition to federal securities laws, "Blue Sky Laws" are state laws that protect the investing public through registration requirements for both broker-dealers and securities offerings, merit review of offerings, and various investor remedies for fraudulent sales practices and activities.[25]

In Florida, the Office of Financial Regulation (OFR)[26] administers the Securities and Investor Protection Act, ch. 517, F.S., (act). The OFR regulates and registers the offer and sale of securities in, to, or from Florida by firms, branch offices, and individuals affiliated with these firms in accordance with the act. There are 2,577 dealers, 6,307 investment advisers, 10,479 branches, and 325,939 associated persons (or stockbrokers) registered in Florida.[27]

The act requires the following individuals or businesses to be registered with the OFR under s. 517.12, F.S., in order to sell or offer to sell any securities in or from offices in this state, or to sell securities to persons in this state from offices outside this state:[28]

- "Dealer," includes any person, other than an associated person registered under ch. 517, F.S., who engages, directly or indirectly, as broker or principal in the business of offering, buying, selling, or otherwise dealing or trading in securities issued by another person. The term, "Dealer," also includes any issuer who through persons directly compensated or controlled by the issuer engages, either for all or part of her or his time, directly or indirectly, in the

[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] U.S. Securities and Exchange Commission, *Blue Sky Laws*, http://www.sec.gov/answers/bluesky.htm (last visited Feb. 19, 2018).
[26] The OIR reports to the Financial Services Commission, which is comprised of the Governor, Attorney General, Chief Financial Officer, and the Commissioner of Agriculture and Consumer Services. Section 20.121, F.S.
[27]Office of Financial Regulation, *Fast Facts* (2018 Edition) at https://www.flofr.com/sitePages/documents/FastFacts.pdf (last viewed Jan. 20, 2020).
[28] Section 517.12(1), F.S.

business of offering or selling securities, which are issued or are proposed to be issued by the issuer.[29]

- "Investment adviser," includes any person who receives compensation, directly or indirectly, and engages for all or part of her or his time, directly or indirectly, or through publications or writings, in the business of advising others as to the value of securities or as to the advisability of investments in, purchasing of, or selling of securities, except a dealer whose performance of these services is solely incidental to the conduct of her or his business as a dealer and who receives no special compensation for such services.[30]
  The term, does not include a "federal covered adviser."[31]
- "Associated persons," with respect to a federal covered adviser, includes any person who is an investment adviser representative and who has a place of business in this state, and with respect to a dealer or investment adviser, includes any of the following:
  - Any partner, officer, director, or branch manager of a dealer or investment adviser or any person occupying a similar status or performing similar functions;
  - Any natural person directly or indirectly controlling or controlled by such dealer or investment adviser, other than an employee whose function is only clerical or ministerial; or
  - Any natural person, other than a dealer, employed, appointed, or authorized by a dealer, investment adviser, or issuer to sell securities in any manner or act as an investment adviser as defined in s. 517.021, F.S.[32]

North American Securities Administrators Association

The North American Securities Administrators Association (NASAA) is an international organization devoted to investor protection. Its membership consists of securities administrators. The NASAA adopted the Model Legislation or Regulation to Protect Vulnerable Adults from Financial Exploitation (Model Act) on January 22, 2016.[33] The Model Act focuses on the reporting and prevention of senior financial exploitation. The Model Act contains the following:

- Mandatory reporting to the state securities regulator and state adult protective services agency when a qualified individual[34] has a reasonable belief that financial exploitation of an eligible adult has been attempted or occurred of broker-dealers and investment advisers;
- Notification to third-parties of potential financial exploitation with advance consent of the investor;
- Authority to temporarily delay disbursement of funds;

[29] Section 517.021(6)(a), F.S. The term "dealer," as defined under Florida law, encompasses the definitions of "broker" and "dealer" under federal law. See also s. 517.12(22)(a)1., F.S.
[30] Section 517.021(14)(a), F.S.
[31] Section 517.021(9) and (14)(b)9., F.S. A federal covered adviser must be registered under federal law and must provide a notice filing to the OFR. Sections 517.021 and 517.1201, F.S.
[32] Section 517.021(2), F.S.
[33] *NASAA Adopt Model Act to Protect Seniors and Vulnerable Adults* at http://serveourseniors.org/about/policy-makers/nasaa-model-act/ (last viewed Jan. 20, 2020).
[34] A "qualified individual" means any agent, investment adviser representative or person who serves in a supervisory, compliance, or legal capacity for a broker-dealer or investment adviser. *See* Section 2 of the Model Act.

- Immunity from civil and administrative liability for a qualified individual, broker-dealer or investment adviser that, in good faith and exercising reasonable care, complies with the reporting, notification, and delay disbursement provisions; and
- Mandatory sharing of records related to exploitation with law enforcement and state adult protective services agencies.

As of January 1, 2019, twenty five states have adopted legislation or regulations consistent with the Model Act.[35]

III. Effect of Proposed Changes:

Mandatory Reporting of Suspected Financial Exploitation

Section 1 amends s. 415.1034, F.S., to specify that a dealer, an investment adviser, or an associated person who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited to report such information or suspicion to Adult Protective Services within the Department of Children and Families through the central abuse hotline. Currently, s. 415.1034, F.S., requires *any person* who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited to report suspected abuse to the central abuse hotline immediately.

Conditions for Delaying a Disbursement or Transaction of Funds or Securities

Section 2 creates s. 517.34, F.S., to allow a dealer or investment adviser to delay a disbursement or transaction of funds or securities from an account of a specified adult or an account for which a specified adult is a beneficiary or beneficial owner.

The bill defines the following terms:

- A "specified adult" is an individual who is age 65 or older or who meets the definition of "vulnerable adult" pursuant to s. 415.1034, F.S., the Adult Protective Services Act.
- "Financial exploitation" means the wrongful or unauthorized taking, withholding, appropriation, or use of money, assets, or property of a specified adult; or any act or omission by a person, including through the use of a power of attorney, guardianship, or conservatorship of a specified adult, to:
  - Obtain control over the specified adult's money, assets, or property through deception, intimidation, or undue influence to deprive him or her of the ownership, use, benefit, or possession of the money, assets, or property; or
  - Convert the specified adult's money, assets, or property to deprive him or her of the ownership, use, benefit, or possession of the money, assets, or property.
- "Trusted contact" means a natural person 18 years of age or older who the account owner has expressly identified and who is recorded in the books and records of a dealer or an investment adviser as the person who may be contacted about the account.

[35] NASAA Model Act to Protect Vulnerable Adults from Financial Exploitation Update Center at http://serveourseniors.org/about/policy-makers/nasaa-model-act/update/ (last viewed Jan. 22, 2020).

An investment adviser or dealer may delay a disbursement or transaction if the following conditions are met:

- The dealer or investment adviser reasonably believes that financial exploitation of the specified adult has occurred, is occurring, has been attempted, or will be attempted in connection with the disbursement or transaction.
- No later than 3 business days after the date on which the delay was first placed, the dealer or investment adviser notifies in writing all parties authorized to transact business on the account and any trusted contact on the account, using the contact information provided on the account, unless the dealer or investment adviser believes that any of the parties are involved in the suspected exploitation. The notice, which may be provided electronically, must provide the reason for the delay.
- No later than 3 business days after the date on which the delay was first placed, the dealer or investment adviser notifies the OFR of the delay by telephone using a number designated by the OFR for such purpose or electronically on a form prescribed by commission rule. The notice must identify the dealer or investment adviser that made the delay, the name of the person who authorized the delay, and the date on which the delay was made.
- The dealer or investment adviser immediately initiates an internal review of the facts and circumstances that caused the dealer or investment adviser to reasonably believe that the financial exploitation of the specified adult has occurred, is occurring, has been attempted, or will be attempted.

Such a delay in a disbursement or transaction expires within 15 business days after the date on which the delay was first placed. However, the delay may be extended for up to 10 additional business days if the dealer's or investment adviser's review of the available facts or circumstances continues to support such dealer's or investment adviser's reasonable belief that financial exploitation of the specified adult has occurred. A dealer or broker must notify the OFR of any extension of a delay. A court of competent jurisdiction may shorten or extend the length of any delay.

Legislative Findings and Intent

The Legislature finds that many persons in this state, because of age or disability, are at increased risk of financial exploitation and loss of their assets, funds, investments, and investment accounts. The Legislature further finds that senior investors in this state are at a statistically higher risk of being targeted for financial exploitation, regardless of diminished capacity or other disability, because of their accumulation of substantial assets and wealth compared to younger age groups. In enacting this section, the Legislature recognizes the freedom of specified adults to manage their assets, make investment choices, and spend their funds, and intends that such rights may not be infringed absent a reasonable belief of financial exploitation as provided in this section.

The Legislature therefore intends to provide for the prevention of financial exploitation of such persons. The Legislature intends to encourage the constructive involvement of securities dealers, investment advisers, and associated persons who take action based upon the reasonable belief that specified adults with investment accounts have been or are the subject of financial exploitation, and to provide securities dealers, investment advisers, and associated persons immunity from liability for taking actions as authorized by the bill. The Legislature intends to

balance the rights of specified adults to direct and control their assets, funds, and investments and exercise their constitutional rights consistent with due process with the need to provide securities dealers, investment advisers, and associated persons the ability to place narrow, time-limited restrictions on these rights in an effort to decrease specified adults' risk of loss due to abuse, neglect, or financial exploitation.

Immunity

The bill grants immunity from any administrative or civil liability that might otherwise arise from a delay in a disbursement or transaction to any dealer, investment adviser, or associated person who in good faith and exercising reasonable care complies with the provisions of s. 517.34, F.S. This provision does not supersede or diminish any immunity granted under ch. 415, F.S.

Obligations and Rights of a Dealer, Investment Adviser, or an Associated Person

The bill does not alter the obligation of a dealer, an investment adviser, or an associated person to comply with instructions from a client absent a reasonable belief of financial exploitation. The bill does not create new rights or obligations of a dealer, investment adviser, or associated person under other applicable laws or rules. The bill does not limit the right of a dealer, investment adviser, or associated person to refuse to place a delay on a transaction or disbursement under other laws or rules or under a customer agreement.

Training, Policies, and Procedures

Prior to placing a delay on a disbursement or transaction, a dealer or investment adviser must comply with the following:

- Develop training policies or programs reasonably designed to educate associated persons on issues pertaining to financial exploitation;
- Conduct training for all associated persons at least annually and maintain a written record of all trainings conducted; and
- Develop, maintain, and enforce written procedures regarding the manner in which suspected financial exploitation is reviewed internally, including, if applicable, the manner in which suspected financial exploitation is required to be reported to supervisory personnel.

Effective Date

Section 3 provides the bill takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Indeterminate. However, the bill will provide additional tools for dealers, investment advisers, and associated persons to protect individuals 65 years of age or older and vulnerable adults from alleged financial exploitation in a more effective and expedient manner.

C. Government Sector Impact:

The fiscal impact to the OFR is indeterminate and depends on the number of reports of delays or extensions received from OFR licensees. The OIR will review these delays to determine whether they are proper and whether the delays comply with the requirements of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 415.1034 of the Florida Statutes.

This bill creates section 517.34 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Broxson

1-00955B-20 20201672__

A bill to be entitled

An act relating to the protection of vulnerable investors; amending s. 415.1034, F.S.; requiring securities dealers, investment advisers, and associated persons to immediately report knowledge or suspicion of abuse, neglect, or exploitation of vulnerable adults to the Department of Children and Families' central abuse hotline; creating s. 517.34, F.S.; defining terms; providing legislative findings and intent; authorizing dealers and investment advisers to delay disbursements or transactions of funds or securities from certain accounts associated with specified adults if certain conditions are met; specifying the expiration of a delay; authorizing dealers and investment advisers to extend delays under certain circumstances; providing requirements for notifying the Office of Financial Regulation; authorizing a court of competent jurisdiction to shorten or extend a delay; requiring dealers and investment advisers to make certain records available to the office upon request; providing for administrative and civil immunity for dealers, investment advisers, and associated persons; specifying training and written procedures requirements for dealers and investment advisers before they may place a delay; providing for rulemaking by the Financial Services Commission; providing construction; providing an effective date.

1-00955B-20 20201672__

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

Section 1. Paragraph (a) of subsection (1) of section 415.1034, Florida Statutes, is amended to read:

415.1034 Mandatory reporting of abuse, neglect, or exploitation of vulnerable adults; mandatory reports of death.—

(1) MANDATORY REPORTING.—

(a) Any person, including, but not limited to, any:

1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;

2. Health professional or mental health professional other than one listed in subparagraph 1.;

3. Practitioner who relies solely on spiritual means for healing;

4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;

5. State, county, or municipal criminal justice employee or law enforcement officer;

6. Employee of the Department of Business and Professional Regulation conducting inspections of public lodging establishments under s. 509.032;

7. Florida advocacy council or Disability Rights Florida member or a representative of the State Long-Term Care Ombudsman Program; ~~or~~

8. Bank, savings and loan, or credit union officer,

trustee, or employee; or

9. Dealer, investment adviser, or associated person under chapter 517,

who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited must ~~shall~~ immediately report such knowledge or suspicion to the central abuse hotline.

Section 2. Section 517.34, Florida Statutes, is created to read:

517.34 Protection of specified adults.—

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

(a) "Financial exploitation" means the wrongful or unauthorized taking, withholding, appropriation, or use of money, assets, or property of a specified adult; or any act or omission by a person, including through the use of a power of attorney, guardianship, or conservatorship of a specified adult, to:

1. Obtain control over the specified adult's money, assets, or property through deception, intimidation, or undue influence to deprive him or her of the ownership, use, benefit, or possession of the money, assets, or property; or

2. Convert the specified adult's money, assets, or property to deprive him or her of the ownership, use, benefit, or possession of the money, assets, or property.

(b) "Specified adult" means a natural person 65 years of age or older, or a vulnerable adult as defined in s. 415.102.

(c) "Trusted contact" means a natural person 18 years of age or older who the account owner has expressly identified and

who is recorded in a dealer's or investment adviser's books and records as the person who may be contacted about the account.

(2) The Legislature finds that many persons in this state, because of age or disability, are at increased risk of financial exploitation and loss of their assets, funds, investments, and investment accounts. The Legislature further finds that senior investors in this state are at a statistically higher risk of being targeted for financial exploitation, regardless of diminished capacity or other disability, because of their accumulation of substantial assets and wealth compared to younger age groups. In enacting this section, the Legislature recognizes the freedom of specified adults to manage their assets, make investment choices, and spend their funds, and intends that such rights may not be infringed absent a reasonable belief of financial exploitation as provided in this section. The Legislature therefore intends to provide for the prevention of financial exploitation of such persons. The Legislature intends to encourage the constructive involvement of securities dealers, investment advisers, and associated persons who take action based upon the reasonable belief that specified adults with investment accounts have been or are the subject of exploitation, and to provide securities dealers, investment advisers, and associated persons immunity from liability for taking actions as authorized herein. The Legislature intends to balance the rights of specified adults to direct and control their assets, funds, and investments and exercise their constitutional rights consistent with due process with the need to provide securities dealers, investment advisers, and associated persons the ability to place narrow, time-limited

restrictions on these rights in an effort to decrease specified adults' risk of loss due to abuse, neglect, or exploitation.

(3) A dealer or investment adviser may delay a disbursement or transaction of funds or securities from an account of a specified adult or an account for which a specified adult is a beneficiary or beneficial owner if all of the following apply:

(a) The dealer or investment adviser reasonably believes that financial exploitation of the specified adult has occurred, is occurring, has been attempted, or will be attempted in connection with the disbursement or transaction.

(b) Not later than 3 business days after the date on which the delay was first placed, the dealer or investment adviser notifies in writing all parties authorized to transact business on the account and any trusted contact on the account, using the contact information provided for the account, with the exception of any party the dealer or investment adviser reasonably believes engaged or is engaging in the suspected financial exploitation of the specified adult. The notice, which may be provided electronically, must provide the reason for the delay.

(c) Not later than 3 business days after the date on which the delay was first placed, the dealer or investment adviser notifies the office of the delay by telephone using a number designated by the office for such purpose or electronically on a form prescribed by commission rule. The notice must identify the dealer or investment adviser that made the delay, the name of the person who authorized the delay, and the date on which the delay was made.

(d) The dealer or investment adviser immediately initiates an internal review of the facts and circumstances that caused

the dealer or investment adviser to reasonably believe that the financial exploitation of the specified adult has occurred, is occurring, has been attempted, or will be attempted.

(4) A delay on a disbursement or transaction under subsection (3) expires 15 business days after the date on which the delay was first placed. However, the dealer or investment adviser may extend the delay for up to 10 additional business days if the dealer's or investment adviser's review of the available facts and circumstances continues to support such dealer's or investment adviser's reasonable belief that financial exploitation of the specified adult has occurred, is occurring, has been attempted, or will be attempted. A dealer or investment adviser who extends a delay shall notify the office in accordance with paragraph (3)(c) not later than 3 business days after the date on which the extension was applied. The notice must identify the dealer or investment adviser that extended the delay and the date on which the delay was originally made. The length of the delay may be shortened or extended at any time by a court of competent jurisdiction. This subsection does not prevent a dealer or investment adviser from terminating a delay after communication with the parties authorized to transact business on the account and any trusted contact on the account.

(5) A dealer or investment adviser must make available to the office, upon request, all records relating to a delay made by the dealer or investment adviser pursuant to this section, as prescribed by commission rule.

(6) A dealer, an investment adviser, or an associated person who in good faith and exercising reasonable care complies

with this section is immune from any administrative or civil liability that might otherwise arise from such delay in a disbursement or transaction in accordance with this section. This subsection does not supersede or diminish any immunity granted under chapter 415.

(7) Before placing a delay on a disbursement or transaction pursuant to this section, a dealer or an investment adviser shall do all of the following:

(a) Develop training policies or programs reasonably designed to educate associated persons on issues pertaining to financial exploitation.

(b) Conduct training for all associated persons at least annually and maintain a written record of all trainings conducted.

(c) Develop, maintain, and enforce written procedures regarding the manner in which suspected financial exploitation is reviewed internally, including, if applicable, the manner in which suspected financial exploitation is required to be reported to supervisory personnel.

(8) Absent a reasonable belief of financial exploitation as provided in this section, this section does not alter a dealer's, an investment adviser's, or an associated person's obligation to comply with instructions from a client to buy or sell securities, disburse funds or transfer securities from an account, close an account, or transfer an account to another dealer, investment adviser, or associated person.

(9) This section does not create new rights for or impose new obligations on a dealer, an investment adviser, or an associated person under other applicable law. This section does

not limit the right of a dealer, an investment adviser, or an associated person to otherwise refuse or place a delay on a disbursement or transaction under other applicable law or under an applicable customer agreement.

Section 3. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/2020
Meeting Date

1672
Bill Number (if applicable)

Topic Protection of Vulnerable Investors

Amendment Barcode (if applicable)

Name Daniel Olson

Job Title Director of Government Affairs

Address 400 S. Monroe Street
Street

Phone

Tallahassee FL 32399
City *State* *Zip*

Email dan.olson@myfloridalegal.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Office of the Attorney General

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/28/2020
Meeting Date

1672
Bill Number (if applicable)

Topic Protection of Vulnerable Investors

n/a
Amendment Barcode (if applicable)

Name Abigail Vail

Job Title Chief of Staff

Address 101 E. Gaines St.
Street

Phone 850-410-9601

Tallahassee, FL 32399
City *State* *Zip*

Email abby.vail@flofr.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Office of Financial Regulation

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/28/20
Meeting Date

1672
Bill Number (if applicable)

Topic Protection of Vulnerable Investors

Amendment Barcode (if applicable)

Name Courtney Larkin

Job Title Florida Bankers Association

Address 1001 Thomasville Road
Street

Phone 850.209.0061

Tallahassee
City

FL
State

32303
Zip

Email clarkin@flbankers.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Bankers Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

1672
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Sean Stafford

Job Title _____

Address 115 E Park
Street

Phone 727-500

City State Zip

Email _____

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

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

Representing Financial Service, Institute / FSDA

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

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

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

01/28/2020
Meeting Date

SB 1672
Bill Number (if applicable)

Topic Protection of Vulnerable Investors

Amendment Barcode (if applicable)

Name Warren Husband

Job Title

Address PO Box 10909
Street

Tallahassee FL 32302
City *State* *Zip*

Phone (850) 205-9000

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Securities Industry and Financial Markets Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Jan 25
Meeting Date

1672
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name Tim Meenan

Job Title _____

Address 300 S. Duval St.
Street
Tallahassee FL 32302
City *State* *Zip*

Phone (850) 425-4000

Email _____

Speaking: ☐ For ☐ Against ☐ Information

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

Representing National Association of Insurance and Financial Advisors

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Commerce and Tourism, *Chair*
Finance and Tax, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Banking and Insurance

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR JOE GRUTERS
23rd District

January 27th, 2020

The Honorable Doug Broxson, Chair
Committee on Banking and Insurance
37 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Broxson:

I am writing to inform you that Senator Gruters will not be at Committee on Banking and Insurance on 1/28/20 at 12:30 pm.

Warm regards,

Joe Gruters

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

REPLY TO:
❒ 381 Interstate Boulevard, Sarasota, Florida 34240 (941) 378-6309
❒ 324 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5023

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

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Criminal Justice, *Chair*
Infrastructure and Security, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Banking and Insurance
Education

JOINT COMMITTEE:
Joint Administrative Procedures Committee

SENATOR KEITH PERRY
8th District

January 28, 2020

Chair Doug Broxson,

Unfortunately, I will be absent from today's Banking and Insurance Committee meeting. Thank you in advance for your time and understanding.

Sincerely,

W. Keith Perry

REPLY TO:
❒ 2610 NW 43rd Street, Suite 2B, Gainesville, Florida 32606 (352) 264-4040
❒ Marion County Board of Commissioners, 115 SE 25th Avenue, Ocala, Florida 34471
❒ Putnam County Government Complex, 2509 Crill Avenue, Palatka, Florida 32177
❒ 316 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5008

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

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Banking and Insurance Committee **Judge:**

Started: 1/28/2020 4:09:16 PM
Ends: 1/28/2020 5:58:36 PM Length: 01:49:21

4:09:14 PM Meeting called to order. Quorum present.
4:10:33 PM TAB 3 S 1338 by Sen. Wright - Prescription Drug Coverage
4:11:44 PM Senator Wright recognized to present bill.
4:17:08 PM Sen. Lee recognized to explain Amd. #632656
4:18:39 PM Senator Rouson with comments on bill.
4:20:47 PM Audrey Brown, FL Association of Health Plans
4:22:07 PM Question by Sen. Lee of Speaker Audrey Brown
4:23:41 PM Followup question by Senator Lee.
4:24:33 PM Michael Jackson, FL Pharmacy Associations
4:27:30 PM Comments by Sen. Lee - Sen. Lee withdraws Amd. 632656
4:28:12 PM Sen. Wright explains Amd. #275668 - Fav w/o - adopted
4:29:06 PM Sen. Thurston withdraws Amd. 422030
4:30:08 PM Michael Jackson, FL Pharmacy Assoc.
4:32:27 PM Kevin Duane - Pharmacist
4:34:01 PM Senator Broxson with question of sponsor.
4:34:55 PM James Wright, Pharmacist
4:37:15 PM Alex Herwig - SPAR - Small business pharmacies
4:43:07 PM Senator Lee with question of speaker.
4:44:40 PM Dawn Butterfield - Pharmacist
4:51:12 PM Chris Nuland, FL Chapter American College of Physicians
4:53:54 PM Bill Mincy, PPSC/FL Independent Pharmacy Network
5:01:24 PM Barney Bishop III - SPAR
5:02:24 PM Jeff Kottkamp (SPAR)
5:04:42 PM Sen. Lee with question of speaker.
5:07:21 PM Question of Speaker by Chair Broxson.
5:10:35 PM Conner Rose - PCMA
5:11:35 PM Senator Thurston with question of speaker.
5:13:50 PM Motion by Sen. Brandes for time certain vote on S 1338 - 5:20
5:14:27 PM Sen. Rouson with question of speaker
5:16:31 PM Shevaun Harris-ACHA
5:17:48 PM Sen. Lee on debate on bill.
5:18:47 PM Sen. Thurston in debate on bill
5:19:34 PM Sen. Wright recognized to close on bill.
5:19:59 PM Roll call vote on CS/S 1338 - Favorable
5:20:36 PM TAB 2 - S 1564 - Genetic Information for Insurance Purposes
5:21:47 PM Delete all amendment explained by Sen. Stargel.
5:22:46 PM Senator Brandes with question of sponsor.
5:23:27 PM Sen. Rouson with question of Sponsor.
5:24:28 PM Sen. Brandes with question of sponsor.
5:27:35 PM Robert Gleeson - Medical Consultant American Council Life Insurance
5:28:36 PM Question by Sen.Brandes of speaker.
5:30:46 PM Sen. Broxson with question of speaker.
5:33:18 PM Senator Stargel recognized to close on amendment - Voice Votre - adodpted
5:34:59 PM Sal Nuzzo, VP of Policy - The James Madison Institute
5:36:07 PM Sen. Brandes recognized for debate on bill
5:38:00 PM Sen. Lee recognized for debate on bill.
5:38:17 PM Comments by Chair.
5:38:45 PM Sen. Stargel to close on bill.
5:39:24 PM Roll call vote on CS/S 1564 - Favorable
5:40:17 PM Sen. Rouson takes Chair.
5:40:27 PM TAB 5 - S 1672 by Broxson - Protection of Vulnerable Investors
5:40:58 PM Explaination of bill by Sen. Broxson.

5:42:51 PM Sen. Broxson recognized to close on bill.
5:43:04 PM Roll call vote on S 1672 - Favorable
5:43:44 PM TAB 2 - S 1306 by Sen. Thurston - Individual Retirement Accounts
5:44:19 PM Senator Thurston explains the bill.
5:44:41 PM Senator Lee with question of sponsor.
5:46:47 PM Roll call vote on S 1306 - Favorable
5:47:23 PM Gavel passed back to Chair Broxson.
5:48:39 PM TAB 1 - S 924 by Brandes - Civil Actions Against Insurers
5:53:32 PM Fred Cunningham - FJA
5:54:31 PM Dale Swope - Taxpayers against insurance bad faith
5:56:24 PM Sen. Brandes with question of sponsor.
5:58:05 PM Motion by Sen. Brandes to TP.
5:58:13 PM Adjourned by Sen. Lee