**SB 784** by **Gaetz**; (Compare to H 0863) Health Care

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 945492 | A | | S | | RCS | BI, Montford | Delete L.243 - 245: 03/04 03:01 PM |
| 932076 | A | | S | L | RCS | BI, Montford | Delete L.254 - 491: 03/04 03:01 PM |

**SB 522** by **Brandes**; (Identical to H 4007) Division of Bond Finance

**SB 678** by **Diaz de la Portilla**; (Compare to H 0677) Reciprocal Insurers

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 799500 | D | | S | | RCS | BI, Simmons | Delete everything after 03/04 03:01 PM |

**SB 568** by **Richter**; (Identical to H 0825) Family Trust Companies

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 117136 | A | | S | | RCS | BI, Richter | Delete L.139 - 140: 03/04 03:01 PM |
| 118860 | A | | S | | RCS | BI, Richter | Delete L.185 - 207: 03/04 03:01 PM |
| 704630 | A | | S | | RCS | BI, Richter | Delete L.274 - 276: 03/04 03:01 PM |
| 437510 | A | | S | | RCS | BI, Richter | Delete L.305 - 315: 03/04 03:01 PM |
| 612190 | A | | S | | RCS | BI, Richter | btw L.458 - 459: 03/04 03:01 PM |
| 957628 | A | | S | | RCS | BI, Richter | Delete L.503 - 509: 03/04 03:01 PM |

**SB 252** by **Smith**; (Compare to CS/H 0233) Insurance Countersignature Requirements

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 389942 | A | | S | | WD | BI, Smith | Delete L.22 - 57: 03/04 03:01 PM |
| 180092 | A | | S | | RCS | BI, Smith | Delete L.22 - 57: 03/04 03:01 PM |
| 728776 | A | | S | | RCS | BI, Smith | Delete L.58 - 61. 03/04 03:01 PM |

**SB 830** by **Simmons**; (Similar to H 0405) Regulation of Corporation Not for Profit Self-insurance Funds

**The Florida Senate**

# COMMITTEE MEETING EXPANDED AGENDA

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

**MEETING DATE:** Wednesday, March 4, 2015
**TIME:** 1:00 —3:00 p.m.
**PLACE:** *Toni Jennings Committee Room,* 110 Senate Office Building

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

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 1 | **SB 784**<br>Gaetz<br>(Compare H 863) | Health Care; Providing that this act shall be known as the "Right Medicine, Right Time Act"; creating the Clinical Practices Review Commission; requiring a managed care plan that establishes a prescribed drug formulary or preferred drug list to provide a broad range of therapeutic options to the patient; requiring sufficient clinical evidence to support a proposed coverage limitation at the point of service; requiring the commission to evaluate the sufficiency of the evidence and the Office of Insurance Regulation to approve coverage limitations on the basis of the commission's evaluation, etc.<br><br>BI 03/04/2015 Fav/CS<br>HP<br>AP | Fav/CS<br>Yeas 11 Nays 0 |
| 2 | **SB 522**<br>Brandes<br>(Identical H 4007) | Division of Bond Finance; Deleting a requirement that the division issue a regular newsletter to certain parties which addresses local and state bonds, etc.<br><br>GO 02/17/2015 Favorable<br>BI 03/04/2015 Favorable<br>FP | Favorable<br>Yeas 11 Nays 0 |
| 3 | **SB 678**<br>Diaz de la Portilla<br>(Compare H 677) | Reciprocal Insurers; Authorizing a reciprocal insurer to distribute a portion of unassigned funds up to a specified limit if approved by the Office of Insurance Regulation; providing that such distribution may not unfairly discriminate between classes of risks or policies or between subscribers, etc.<br><br>BI 03/04/2015 Fav/CS<br>CM<br>RC | Fav/CS<br>Yeas 11 Nays 0 |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 4 | **SB 568**<br>Richter<br>(Identical H 825) | Family Trust Companies; Revising the purposes of the Family Trust Company Act; specifying the applicability of other chapters of the financial institutions codes to family trust companies; revising the requirements for investigations of license applicants by the Office of Financial Regulation; revising the requirements for registration of a family trust company and a foreign licensed family trust company; deleting the requirement that the office examine a family trust company that is not licensed and a foreign licensed family trust company, etc.<br><br>BI 03/04/2015 Fav/CS<br>JU<br>FP | Fav/CS<br>Yeas 11 Nays 0 |
| 5 | **SB 252**<br>Smith<br>(Compare CS/H 233) | Insurance Countersignature Requirements; Providing that the absence of a countersignature does not affect the validity of a policy or contract of insurance; reenacting provisions to incorporate the amendment made to s. 624.425, F.S., in references thereto; providing that the act is remedial and intended to clarify existing law; providing for retroactive application, etc.<br><br>BI 03/04/2015 Fav/CS<br>JU<br>RC | Fav/CS<br>Yeas 11 Nays 0 |
| 6 | **SB 830**<br>Simmons<br>(Similar H 405) | Regulation of Corporation Not for Profit Self-insurance Funds; Revising the requirements for a participating member of a corporation not for profit self-insurance fund, etc.<br><br>BI 03/04/2015 Temporarily Postponed<br>CM<br>FP | Temporarily Postponed |
| | Other Related Meeting Documents | | |

945492

LEGISLATIVE ACTION

| Senate | . | House |
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| Comm: RCS | . | |
| 03/04/2015 | . | |
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The Committee on Banking and Insurance (Montford) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 243 - 245

and insert:

6. Managed care plans shall only establish coverage limitations that are supported by sufficient clinical evidence as defined by 627.6051(1). The agency may not approve coverage limitations without an assessment of the supporting evidence by the Clinical Services Review Commission established pursuant to s. 402.90.

945492

11
12 ================ T I T L E  A M E N D M E N T ================
13 And the title is amended as follows:
14 Delete lines 19 - 20
15 and insert:
16 therapeutic options to the patient; requiring coverage
17 limitations to be supported by clinical evidence;
18 setting coverage limitation approval standards;

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LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 03/04/2015 | . | |
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| | . | |
| | . | |

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

**Senate Amendment (with title amendment)**

Delete lines 254 - 491

and insert:

condition for the covered patient.

(a) For purposes of this section, the term, "a coverage limitation imposed at the point of service" means a limitation that is not universally applicable to all covered lives, but instead depends on an insurer's consideration of specific patient characteristics and conditions that have been reported

932076

by a physician in the process of providing medical care.

(b) The term "sufficient clinical evidence" means:

1. A body of research consisting of well-controlled studies conducted by independent researchers and published in peer reviewed journals or comparable publications which consistently support the treatment protocol or other coverage limitation as a best practice for the specific diagnosis or combination of presenting complaints.

2. Results of a multivariate predictive model which indicate that the probability of achieving desired outcomes is not negatively altered or delayed by adherence to the proposed protocol.

(2) The Clinical Practices Review Commission established under s. 402.90 shall determine whether sufficient clinical evidence exists for a proposed coverage limitation imposed by the insurer at the point of service. In each instance in which the commission finds that sufficient clinical evidence exists to support a coverage limitation, the office shall approve the coverage limitation.

(3) If an insurer, without the approval of the office, imposes a coverage limitation at the point of service, including, but not limited to, a prior authorization procedure, step therapy requirement, treatment protocol, or other utilization management procedure that restricts access to covered services, the insurer and its chief medical officer shall be liable for any injuries or damages, as defined in s. 766.202, and economic damages, as defined in s. 768.81(1)(b), that result from the restricted access to services determined medically necessary by the physician treating the patient. An

932076

insurer that imposes such a coverage limitation at the point of service shall establish reserves sufficient to pay for such damages.

Section 5. Subsection (2) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

(2) The outline of coverage must ~~shall~~ contain:

(a) A statement identifying the applicable category of coverage afforded by the policy, based on the minimum basic standards set forth in the rules issued to effect compliance with s. 627.643.

(b) A brief description of the principal benefits and coverage provided in the policy.

(c) A summary statement of the principal exclusions and limitations or reductions contained in the policy, including, but not limited to, preexisting conditions, probationary periods, elimination periods, deductibles, coinsurance, and any age limitations or reductions.

(d) A summary statement identifying specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol. The insurer shall post the summary statement at a prominent and readily accessible location on the Internet.

(e) A summary statement identifying any specific diagnostic or therapeutic procedures that are subject to prior authorization or other coverage limitations and the applicable coverage limitation policy or protocol. The insurer shall post the summary statement at a prominent and readily accessible

location on the Internet.

(f) ~~(d)~~ A summary statement of the renewal and cancellation provisions, including any reservation of the insurer of a right to change premiums.

(g) ~~(e)~~ A statement that the outline contains a summary only of the details of the policy as issued or of the policy as applied for and that the issued policy should be referred to for the actual contractual governing provisions.

(h) ~~(f)~~ When home health care coverage is provided, a statement that such benefits are provided in the policy.

Section 6. Subsection (2) of section 627.6471, Florida Statutes, is amended to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(2) An ~~Any~~ insurer issuing a policy of health insurance in this state that~~, which insurance~~ includes coverage for the services of a preferred provider~~,~~ must provide each policyholder and certificateholder with a current list of preferred providers, ~~and~~ must make the list available for public inspection during regular business hours at the principal office of the insurer within the state, and must post a link to the list of preferred providers on the home page of the insurer's website. Such insurer must post on its website a change to the list of preferred providers within 10 business days after such change.

Section 7. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

627.651 Group contracts and plans of self-insurance must meet group requirements.—

(4) This section does not apply to any plan that ~~which~~ is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8) ~~627.662(7)~~. This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 8. Present subsections (7) through (14) of section 627.662, Florida Statutes, are redesignated as subsections (8) through (15), respectively, and a new subsection (7) is added to that section, to read:

627.662 Other provisions applicable.—The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(7) Section 627.642(2)(d) and (e), relating to coverage limitations on prescription drugs and diagnostic or therapeutic procedures.

Section 9. Paragraph (b) of subsection (12) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.—

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a

high deductible plan that meets the requirements of a health savings account plan as defined by federal law or a health reimbursement arrangement as authorized by the Internal Revenue Service, which ~~that~~ meet the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan," "basic health benefit plan," and "high deductible plan" mean policies or contracts that a small employer carrier offers to eligible small employers which ~~that~~ contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; ~~and~~

b. A procedure for preauthorization or prior authorization by the small employer carrier, or its designees;

c. A summary statement identifying specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol. The carrier shall post the summary statement in a prominent and readily accessible location on the Internet; and

d. A summary statement identifying any specific diagnostic or therapeutic procedures subject to prior authorization or other coverage limitations and the applicable coverage limitation policy or protocol. The carrier shall post the summary statement in a prominent and readily accessible location on the Internet.

3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the office, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to

s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for children with disabilities ~~handicapped children~~ pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan must ~~shall~~ include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan must ~~shall~~ place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding such ~~said~~ provisions, the plans may specify limits on the number of



authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. The high-deductible ~~high deductible~~ plan associated with a health savings account or a health reimbursement arrangement must ~~shall~~ include all the benefits specified in subparagraph 4.

9. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association if ~~when~~ such services are available and the osteopathic hospital agrees to provide the service.

Section 10. Subsection (4) of section 641.31, Florida Statutes, is amended and subsection (44) is added to that section, to read:

641.31 Health maintenance contracts.—

(4) Each ~~Every~~ health maintenance contract, certificate, or member handbook must ~~shall~~ clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the benefits, services, or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity that ~~which~~ is underwriting any of the services offered by the health maintenance organization. The contract, certificate, or member handbook must ~~shall~~ also state where and in what manner the comprehensive health care services may be obtained. The health maintenance organization shall prominently post the statement regarding limitations on benefits, services, or kinds of services provided on its website in a readily accessible

932076

location on the Internet. The statement must include, but need not be limited to:

(a) The identification of specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol.

(b) The identification of any specific diagnostic or therapeutic procedures that are subject to prior authorization or other coverage limitations and the applicable coverage limitation policy or protocol.

(44) Health maintenance organizations are prohibited from establishing prior authorization procedures, step therapy requirements, treatment protocols, or other utilization management procedures that restrict access to covered services unless expressly authorized to do so under this subsection. A coverage limitation imposed by a health maintenance organization at the point of service must be supported, as determined by the Clinical Practices Review Commission established pursuant to s. 402.90, by sufficient clinical evidence, as defined in s. 627.6051(1), which demonstrates that the limitation does not inhibit the timely diagnosis or optimal treatment of the specific illness or condition for the covered patient. For purposes of this subsection, the term, "a coverage limitation imposed by a health maintenance organization at the point of service" means a limitation that is not universally applicable to all covered lives, but instead depends on a health maintenance organization's consideration of specific patient characteristics and conditions that have been reported by a physician in the process of providing medical care.

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Section 11. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility more than 1 year after the date of payment of the claim and may not retroactively deny a claim because of subscriber ineligibility at any time if the health maintenance organization verified the eligibility of a subscriber at the time of treatment and has provided an authorization number.

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

And the title is amended as follows:

Delete lines 23 - 62

and insert:

limitation at the point of service; defining the terms "a coverage limitation imposed at the point of service" and "sufficient clinical evidence"; requiring the commission to determine whether sufficient clinical evidence exists and the Office of Insurance Regulation to approve coverage limitations if the commission determines that such evidence exists; providing for the liability of a health insurer and its chief medical officer for injuries and damages resulting from restricted access to services if the insurer has imposed coverage limitations without the approval of the office; requiring insurers to establish reserves to pay for such damages; amending ss. 627.642 and 627.6699, F.S.; requiring an outline

of coverage and certain plans offered by a small employer carrier to include summary statements identifying specific prescription drugs and procedures that are subject to specified restrictions and limitations; requiring insurers and small employer carriers to post the summaries on the Internet; amending s. 627.6471, F.S.; requiring an insurer to post a link to the list of preferred providers on its website and to update the list within 10 business days after a change; amending s. 627.651, F.S.; conforming a cross-reference; amending s. 627.662, F.S.; specifying that specified provisions relating to coverage limitations on prescription drugs and diagnostic or therapeutic procedures apply to group health insurance, blanket health insurance, and franchise health insurance; amending s. 641.31, F.S.; requiring a health maintenance contract summary statement to include a statement of any limitations on benefits, the identification of specific prescription drugs, and certain procedures that are subject to specified restrictions and limitations; requiring a health maintenance organization to post the summaries on the Internet; prohibiting a health maintenance organization from establishing certain procedures and requirements that restrict access to covered services; requiring a coverage limitation to be supported, as determined by the commission, by clinical evidence demonstrating that the limitation does not inhibit the diagnosis or treatment of the patient; defining the


term "a coverage limitation imposed at the point of service"; amending s. 641.3155, F.S.; prohibiting the retroactive denial of a claim because of subscriber ineligibility at any time if the health maintenance organization verified the eligibility of such subscriber at the time of treatment and provided an authorization number; providing an effective date.

**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 784 |
| INTRODUCER: | Banking and Insurance Committee and Senator Gaetz |
| SUBJECT: | Health Care |
| DATE: | March 5, 2015 |
| REVISED: | |

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

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 784 creates the "Right Medicine, Right Time Act." The bill establishes the Clinical Practices Review Commission within the Department of Health. The commission will review prior authorization, step therapy, or other protocols, submitted by health maintenance organizations, insurers, or Medicaid managed care plans, that limit access to covered services at the point of service to determine if the limitation is supported by sufficient clinical evidence which proves that the limitation does not inhibit timely diagnosis or effective treatment of the specific illness or condition of the covered patient.

Any coverage limitation imposed by a health maintenance organization (HMO), an insurer, or a Medicaid managed care plan must comply with the procedures for approval of coverage limitations by the commission. If the commission finds that sufficient, clinical evidence exists to support a coverage limitation, the Office of Insurance Regulation (insurers and HMOs) or the Agency for Health Care Administration (Medicaid managed care plans) will approve the coverage limitation. If an insurer, without the approval of the Office of Insurance Regulation, imposes a coverage limitation, the insurer and its chief medical officer are liable for any injuries or damages, as defined in s. 766.202, F.S., and economic damages, as defined in s. 768.81(1)(b), F.S. resulting from the patient's restricted access to services determined medically necessary by the treating physician.

The bill requires a Medicaid managed care plan that establishes a prescribed drug formulary or preferred drug list to provide a broad range of therapeutic options for the treatment of diseases. If

feasible, the formulary or preferred drug list must include at least two products in each therapeutic class.

The bill provides greater transparency for consumers regarding participating providers and coverage limitations. Each insurer is required to post a link to the list of preferred providers on the insurer's website and update the list within 10 days after any change in the list. Individual and group health insurance policies and HMO contracts must provide a summary statement identifying any diagnostic or therapeutic procedure that is subject to prior authorization or other coverage limitation as well as prescription drugs that are subject to prior authorization, step therapy or any coverage limitation. The insurer or HMO is required to post the summary statement on the Internet, which will assist consumers in comparing benefits and limitations of each plan.

The bill also revises provisions relating to the prompt payment of claims by HMOs by prohibiting an HMO from retroactively denying a claim because of subscriber ineligibility if the HMO had verified the eligibility of a subscriber at the time of treatment.

## II. Present Situation:

### Regulation of Insurers and Health Maintenance Organizations

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities.[1] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency pursuant to part III of ch. 641, F.S.[2] As part of the certification process used by the agency, 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.[3]

The Florida Insurance Code requires health insurers and HMOs to provide an outline of coverage or other information describing the benefits, coverages, and limitations of a policy or contract. This may include an outline of coverage describing the principal exclusions and limitations of the policy.[4] Section 641.31(4), F.S., requires each contract, certificate, or member handbook of an HMO to delineate the services for which a subscriber is entitled and any limitations under the contract.

### Statewide Medicaid Managed Care

Medicaid is a joint federal and state funded program that provides healthcare for low income Floridians. The Agency for Healthcare Administration (Agency) administers the program. In fiscal year 2013-2014, the agency implemented the legislatively-mandated Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two components: the

[1] Section 20.121(3)(a)1., F.S.
[2] Section 641.21(1), F.S.
[3] Section 641.495, F.S.
[4] Section 627.642, F.S.

Managed Medicaid Assistance (MMA) program and the Long-term Care program. Most Medicaid recipients who are eligible for the full range of Medicaid benefits are enrolled in an MMA plan. Currently, Medicaid managed care plans must provide all prescription drugs listed on the agency's Medicaid preferred drug list (PDL) for at least the first year of operation.

Managed care plans have the ability to implement service authorization and utilization management requirements for the services they provide under the SMMC program. However, Medicaid managed care plans are required to ensure that service authorization decisions are based on objective evidenced-based criteria; utilization management procedures are applied consistently; and all decisions to deny or limit a requested service are made by health care professionals who have the appropriate clinical expertise in treating the enrollee's condition or disease.[5] The managed care plans are also required to adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; consider the needs of the enrollees; are adopted in consultation with providers; and are reviewed and updated periodically, as appropriate. These guidelines are consistent with requirements found in federal regulations.[6]

The agency maintains coverage and limitations policies for most Medicaid services, which are incorporated by reference into the Florida Administrative Code. Medicaid managed care plans cannot be more restrictive than these policies or the Medicaid state plan (which is approved by the federal Centers for Medicare and Medicaid Services) in providing services to their enrollees. Managed care plans must notify enrollees and providers of the services they provide and inform them of any prior authorization requirements or coverage limitations in their respective handbooks.

Section 409.91195, F.S., establishes the Pharmaceutical and Therapeutics (P&T) committee within the agency for developing a Medicaid preferred drug list. The P&T committee meets quarterly, reviews all drug classes included in the formulary at least every 12 months, and may recommend additions to and deletions from the agency's Medicaid PDL, such that the PDL provides for medically appropriate drug therapies for Medicaid recipients and an array of choices for prescribers within each therapeutic class. The agency also manages the federally-required Medicaid Drug Utilization Board, which meets quarterly and develops and reviews clinical prior authorization criteria, including step-therapy protocols for certain drugs that are not on the agency's Medicaid PDL.

Managed care plans serving Managed Medical Assistance enrollees are required to provide all prescription drugs listed on the agency's Medicaid PDL for at least the first year of operation. As such, the managed care plans have not implemented their own plan-specific formulary or PDL. The managed care plan's prior authorization criteria/protocols related to prescribed drugs cannot be more restrictive than the criteria established by the agency. Section 409.967, F.S., currently requires managed care plans to publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that

[5] Agency for Health Care Administration Bill Analysis, SB 784 (February 13, 2015) (on file with Banking and Insurance Committee).
[6] 42 CFR 438.236(b).

the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.

**State Group Insurance**

The Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group insurance program by providing employee benefits such as health, life, dental, and vision insurance products under a cafeteria plan consistent with section 125 of the Internal Revenue Code.[7] As part of the State Group Insurance Program, the DMS contracts with third party administrators for the self-insured State Employees' PPO Plan and four self-insured HMO plans; contracts directly with two fully-insured HMOs; and contracts with a pharmacy benefits manager (PBM) for the State Employees' Prescription Drug Plan.[8] The State Employees' Prescription Drug Plan covers all PPO and HMO plan members (excluding Medicare Advantage Plans offered exclusively to eligible retirees). Summary information about the plans is available on the Internet.[9]

The Division of State Group Insurance indicates that health plan administrators, HMOs and the PBM each have their respective clinical coverage guidelines and utilization management practices to ensure appropriateness of care and to manage plan costs.[10] These coverage guidelines are based on clinical evidence and recommendations from clinical and pharmacy and therapeutics committees comprised of practicing physicians and pharmacists. The National Committee for Quality Assurance and other national accreditation organizations define the structure and function of these committees.

**Cost Containment Measures Used by Insurers and HMOs**

Insurers use many cost containment strategies to manage medical and drug spending and utilization. For example, plans may place utilization management requirements on the use of certain drugs on their formulary, such as requiring enrollees to obtain prior authorization from their plan before being able to fill a prescription, requiring enrollees to first try a preferred drug to treat a medical condition before being able to obtain an alternate drug for that condition, or limiting the quantity of drugs that they cover over a certain period of time.

Under prior authorization, a health care provider is required to seek approval from an insurer before a patient may receive a specified diagnostic or therapeutic treatment or specified prescription drugs under the plan. A PDL is an established list of one or more prescription drugs within a therapeutic class deemed clinically equivalent and cost effective. In order to obtain another drug within the therapeutic class, not part of the PDL, prior authorization is required.

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[7] Section 110.123, F.S.
[8] Section 110.12315, F.S.
[9] Summary plan descriptions and certificates of coverage for the state group health insurance program are available at http://mybenefits.myflorida.com/health/forms_and_resources/forms_and_publications/health_insurance_forms_and_publications and on the respective vendor websites.
[10] Department of Management Services, SB 784 Analysis (February 26, 2015) (on file with Senate Banking and Insurance Committee).

Prior authorization for emergency services is not required. Preauthorization for hospital inpatient services is generally required.

In some cases, plans require an insured to try one drug first to treat his or her medical condition before they will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, a plan may require doctors to prescribe Drug A first. If Drug A does not work for a beneficiary, then the plan will cover Drug B. Advocates of step therapy state that a step therapy approach requires the use of clinically recognized first-line drug before approval of a more complex and often more expensive medication where the safety, effectiveness, and values has been well established before a second-line drug is authorized.

According to a published report by researchers affiliated with the National Institutes of Health, there is mixed evidence on the impact of step therapy policies.[11] A review of the literature by Brenda Motheral found that there is little good empirical evidence,[12] but other studies[13] suggest that step therapy policies have been effective at reducing drug costs without increasing the use of other medical services. However, some studies have found that the policies can increase total utilization costs over the long run because of increased inpatient admissions and emergency department visits.[14] One-step therapy policy for a typical antipsychotic medication in a Medicaid program was associated with a higher rate of discontinuity in medication use, an outcome that was linked to increased risk for hospitalization.[15]

Federal regulations for Medicaid and the Children's Health Insurance Program (or CHIP, which, in Florida, is known as Kidcare) require that managed care plans have written policies and procedures for initial and continuing authorization decisions that ensure timely access to care for enrollees with serious and chronic conditions.[16] Under these federal regulations, prior authorization decisions may not exceed 14 calendar days following receipt of the request, with a possible extension up to 14 additional calendar days if requested by the enrollee or provider or there is a need for additional information. For Medicaid, an expedited authorization process is also provided that does not exceed 3 working days with the ability to extend up to 14 calendar days upon enrollee request, or if the managed care plan justifies a need for additional information and the extension is in the enrollee's benefit.[17] Regulations governing the CHIP provide a deferral to any existing state law on the authorization of health services, if applicable.[18]

Recently, the Banking and Insurance Committee staff surveyed insurers and HMOs regarding their use of prior authorization, step therapy, and P&T Committees. The four companies surveyed have Pharmacy and Therapeutic Committees. Respondents indicated that prior authorization and step therapy could be used for multiple purposes, such as patient safety, expectation of long-term health outcomes, overutilization of a service related to evidence based

[11] The Ethics Of 'Fail First': Guidelines and Practical Scenarios for Step Therapy Coverage Policies, Rahul K. Nayak and Steven D. Pearson *Health Affairs* 33, No.10 (2014):1779-1785.
[12] Pharmaceutical Step Therapy Interventions: A Critical Review of the Literature, Brenda R. Motheral, *Journal of Managed Care Pharmacy* 17, no. 2 (2011) 143-55.
[13] See fn. 11 at pg. 1780.
[14] See *id*.
[15] See *id*.
[16] See 42 CFR 438.210 (Medicaid) and 42 CFR 495 (Children's Health Insurance Program).
[17] 42 CFR 438.210.
[18] 42 CFR 457.495(d)(2).

criteria, and potentially available lower cost solutions with equal health outcomes comparable to higher cost solutions.

**Patient Protection and Affordable Care Act (PPACA)**

The federal PPACA was signed into law on March 23, 2010.[19] The PPACA imposes many insurance requirements including required benefits, coverage for all individuals and employers, rating and underwriting standards, reporting of medical loss ratios and payment of rebates, internal and external appeals of adverse benefit determinations, and other requirements.[20]

Qualifying coverage may be obtained through an employer, the federal or state exchanges created under PPACA, or private individual or group coverage meeting the minimum essential benefits coverage standard. Florida did not establish its own state exchange under PPACA. Premium credits and other cost sharing subsidies are available to U.S. citizens and legal immigrants within certain income limits for qualified coverage purchased through the exchange. Premium credits are set on a sliding scale based on a percentage of the federal poverty level and reduce the out-of-pocket costs incurred by individuals and families.

Prior to an insurer offering a plan through an exchange, an exchange must certify that the plan meets certain requirements to be deemed a qualified health plan (QHP). If a QHP is not certified, the product may be offered outside the exchange, but individuals purchasing that product would not be eligible for a premium subsidy, which are limited to coverage purchased through the exchange. Insurers seeking initial certification or recertification of qualified health plans (QHPs) for the 2016 enrollment must submit applications to Centers for Medicare and Medicaid Services (CMS) by May 15, 2015. The final deadline for state approval and for QHPs to send final data to CMS is August 25, 2015.

***Final HHS Notice of Benefit and Payment Parameters for 2016***

On March 20, 2014, the final HHS regulations relating to notice of benefit and payment parameters was released, which establishes key standards for issuers and marketplaces for 2016. These regulations include provisions relating to prescription drug coverage, formulary drug list, and the drug exception process.[21]

**Prescription Drug Coverage.**[22] The current drug coverage policy of HHS is based on insurers and HMOs including in their formulary drug lists the greater of one drug for each U.S. Pharmacopeia (USP) category and class or the same number of drugs in each USP category and class as the state's essential health benefit (EHB) benchmark plan. Under the final rule, insurers

[19] P.L. 111-148. On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010.
[20] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), (42 U.S.C. 300gg et seq.).
[21] HHS, Final HHS Notice of Benefit and Payment Parameters for 2016 Factsheet, at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2016-PN-Fact-Sheet-final.pdf (last visited March 3, 2015).
[22] 42 U.S.C. 18022 provides for the establishment of an essential health benefits (EHB) package that includes coverage of EHB. The law directs that EHBs be equal in scope to the benefits covered by a typical employer plan and that they cover at least 10 general categories including prescription drugs.

and HMOs must also use a P&T committee system, which will design formularies using scientific evidence that will include consideration of safety and efficacy, cover a range of drugs in a broad distribution of therapeutic categories and classes, and provide access to drugs that are included in broadly accepted treatment guidelines. Insurers and HMOs will use the P&T committee process, starting in 2017, and must also satisfy the current USP drug count standard.

**Formulary Drug List.** The regulations clarify that a health plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the state, the marketplace, HHS, and the general public. Additionally, insurer and HMOs must also make this information available in a standard machine-readable format to provide the opportunity for third parties to create resources that aggregate information on different plans.

**Drug Exceptions Process.** The HHS current regulations require that insurers and HMOs have processes through which an enrollee can request and gain access to a drug not on the formulary. In the final rule, HHS established more detailed procedures for the standard review process, and a requirement that insurers and HMOs have a process in place under which an enrollee can request an independent external review if the health plan denies an initial request made on a standard or expedited basis. HHS also clarified that cost sharing for drugs obtained through the exceptions process must count toward the annual limitation on cost sharing for health plans subject to the EHB requirement.

***Termination of Coverage; Grace Periods***

PPACA requires an insurer or HMO that offers QHPs to establish a standard policy for the termination of coverage of enrollees due to non-payment of premium.[23] This policy must include a grace period for enrollees receiving subsidies[24] on the exchange and must be applied uniformly to enrollees similarly situated.

Pursuant to PPACA, insurers and HMOs must provide a grace period of 3 consecutive months if an enrollee is receiving a subsidy and has previously paid at least one full month's premium during the benefit year. During this grace period for enrollees receiving a subsidy, the insurer or HMO must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may "pend" claims for services rendered to the enrollee in the second and third months of the grace period. The insurer or HMO must notify HHS of such nonpayment and notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. If an enrollee exhausts the 3-month grace period without paying all premiums, the insurer or HMO must terminate coverage effective after the last day of the first month of the 3-month grace period provided the insurer or HMO meets the notice requirements.

The last day of coverage for non-payment of premiums for exchange enrollees not receiving subsidies must comply with state law regarding grace periods for nonpayment.[25] Section

[23] 45 CFR s. 156.270.
[24] Advance payments of the premium tax credit, see http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/The-Premium-Tax-Credit (last visited March 4, 2015).
[25] 45 CFR 155.430(d)(5).

627.608, F.S., requires insurers to provide a 31-day grace period for the payment of premiums. During the grace period, the policy stays in force. If the premium is not paid during this grace period, the claim may be denied retroactively and the policy may be terminated retroactively[26] to the beginning of the grace period. Section 641.31(15), F.S., requires all health maintenance contracts to have a grace period of not less than 10 days. If any required premium is not paid on or before the due date, it may be paid during the following grace period. During the grace period, the contract stays in force. If full payment of the premium is not received by the end of the grace period, coverage terminates as of the grace period start date, and the HMO will retroactively deny the claim. Currently, 641.3155, F.S., limits the ability or an insurer or a HMO to deny a claim retroactively to one year after the date of payment of the claim.

***Summary of Benefits and Coverage***

PPACA directs HHS and the Department of Treasury to develop standards for insurer and HMOs to use in compiling and providing a summary of benefits and coverage (SBC) that ''accurately describes the benefits and coverage under the applicable plan or coverage."[27] On December 30, 2014, HHS issued proposed rules relating to the summary of benefits and coverage that would require insurers and HMOs to provide:[28]

- A description of the coverage, including cost sharing, for each category of benefits.
- The exceptions, reductions, and limitations of the coverage.
- For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage.

## III. Effect of Proposed Changes:

**Section 1** creates the "Right Medicine, Right Time Act."

**Section 2** creates s. 402.90, F.S., and establishes the Clinical Practices Review Commission (commission), which would be housed for administrative purposes within the Division of Medical Quality Assurance of the Department of Health. The commission would consist of the following seven appointed members, subject to confirmation by the Senate:

- Five physicians who are currently practicing medicine in Florida and have clinical expertise as specified in the bill.
- One individual, appointed by the Governor, with a doctorate in pharmacology or pharmacy and meeting specified experience and credentials.
- One member, appointed by the Governor, with expertise in the analysis of clinical research and meeting other requirements.

The powers and duties of the commission include:

- Development and implementation of policies and procedures for the review of prior authorization, step therapy, or other protocols that limit, at the point of service, access to covered services, including diagnostic procedures, pharmaceutical services, and other therapeutic interventions.

[26] Section 627.6131, F.S.
[27] 42 U.S.C. 300gg-15.
[28] *See* Summary of Benefits and Coverage and Uniform Glossary, 79 Fed. Reg. 78,607-78611, (December 30, 2014).

- Development of any operational policies and procedures that would facilitate the work of the commission, including the establishment of bylaws, the election of a chair, and other administrative procedures.
- Determination as to the sufficiency of clinical evidence submitted in support of any proposed coverage limitation.
- Preparation of reports and recommendations that document the proceedings of the commission and identify necessary resources or legislative action.

The bill provides that commission members and specified commission staff are subject to part III, of chapter 112, F.S., including the Code of Ethics for Public Officers and reporting of financial interests pursuant to s. 112.3145, F.S. For purposes of part III of ch. 112, F.S., the executive director, senior managers, commission members are considered public officers or employees and the commission is considered their agency. Each commission member is prohibited from voting on any measure that would inure to his or her special private gain or loss. Similar prohibitions apply to voting on any measure that would benefit any principal, parent organization or subsidiary of a corporate principal by which he or she is retained or to a relative or business associate of the public officer. Senior managers and commission members are required to file the disclosure requirements with the Commission on Ethics. An employee or commission is prohibited from accepting any gift or expenditure from a person which has a contractual relationship with the commission or which is under consideration for a contract. An employee or commission member that fails to comply with these requirements is subject to the penalties provided under ss. 112.317 and 112.3173, F.S.

Subject to an appropriation, a commission member may receive compensation, per diem, and travel expenses as provided in s. 112.061, F.S.

**Section 3** amends s. 409.967, F.S., and establishes requirements for prescribed drug formularies or preferred drug lists of Medicaid managed care plans. If a Medicaid managed care plan establishes a prescribed drug formulary or preferred drug list, the plan must provide a broad range of therapeutic options for the treatment of disease states, which are consistent with the general needs of the outpatient population. If feasible, the formulary or preferred drug list must include at least two products in each therapeutic class. The section also provides that such plans may only establish coverage limitation that are supported by clinical evidence as defined in s. 627.6051, F.S. The agency may not approve coverage limitations without an assessment of the supporting evidence by the commission established pursuant to s. 402.90, F.S.

**Section 4** creates s. 627.6051, F.S., and requires that any coverage limitation imposed by an insurer at the point of services must be supported by sufficient clinical evidence providing that the limitation does not inhibit timely diagnosis or effective treatment of the specific illness or condition for the covered patient. For purposes of this section, the term, "a coverage limitation imposed at the point of service" means a limitations that is not universally applicable to all covered lives, but instead depends on an insurer's consideration of specific patient characteristics and conditions that have been reported by a physician in the process of providing medical care.

The bill defines the term, "sufficient clinical evidence," to mean:

- A body of research consisting of well-controlled studies conducted by independent researchers and published in peer reviewed journals or comparable publications, which

consistently support the treatment protocol or other coverage limitation as a best practice for the specific diagnosis or combination of presenting complaints.
- Results of a multivariate predictive model, which indicate that the probability of achieving desired outcomes is not negatively altered or delayed by adherence to the proposed protocol.

The commission is required to determine whether sufficient clinical evidence exists for a proposed coverage limitation imposed by an insurer at the point of service. If the commission determines that sufficient clinical evidence exists to support a coverage limitation, the OFR must approve the coverage limitation.

If an insurer, without the approval of the OIR, imposes a coverage limitation, the insurer and its chief medical officer are liable for any injuries or damages, as defined in s. 766.202, F.S., and economic damages, as defined in s. 768.81(1)(b), F.S., resulting from the patient's restricted access to services determined medically necessary by the treating physician.

Section 768.81(1)(b), F.S., defines the term, "economic damages" to mean past lost income and future lost income reduced to present value; medical and funeral expenses; lost support and services; replacement value of lost personal property; loss of appraised fair market value of real property; costs of construction repairs, including labor, overhead, and profit; and any other economic loss that would not have occurred but for the injury giving rise to the cause of action.

Section 766.202, F.S., defines the term, "economic damages," to mean financial losses that would not have occurred but for the injury giving rise to the cause of action, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act. "Noneconomic damages" is defined to mean nonfinancial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other nonfinancial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

**Sections 5, 8, and 9** amend ss. 627.642, 627.662, and 627.6699, F.S., to require individual and group health insurance policies to provide a summary statement identifying any diagnostic or therapeutic procedure that is subject to prior authorization or other coverage limitation as well as prescription drugs that are subject to prior authorization, step therapy or any coverage limitation. The insurer is required to post the summary statement on the Internet, which will assist consumers in comparing benefits and limitations of each plan.

**Section 6** amends s. 627.6471, F.S., to require each insurer to post a link to the list of preferred providers on the insurer's website and update the list within 10 days after any change in the list.

**Section 7** amends s. 627.651, F.S., to provide a technical, conforming cross reference.

**Section 10** amends s. 641.31(44), F.S., to require HMO contracts to provide a summary statement identifying any diagnostic or therapeutic procedure that is subject to prior authorization or other coverage limitation as well as prescription drugs that are subject to prior authorization, step therapy or any coverage limitation. The HMO is required to post the summary

statement on the Internet, which will assist consumers in comparing benefits and limitations of each plan.

The section also provides that HMOs are prohibited from establishing prior authorization procedures, step therapy requirements, treatment protocols, or other utilization management procedures that restrict access to covered services unless expressly authorized under this section. Any coverage limitation imposed by a HMO at the point of service must be supported, as determined by the commission by sufficient clinical evidence as defined in s. 627.6051, F.S., which demonstrates that the limitation does not inhibit timely diagnosis or optimal treatment of the specific illness or condition of the covered patient. For purposes of this section, the term, "a coverage limitation imposed by a HMO at the point of service" means a limitation that is not universally applicable to all covered lives, but instead depends on a HMOs's consideration of specific patient characteristics and conditions that have been reported by a physician in the process of providing medical care.

**Section 11** amends s. 641.3155, F.S., relating to prompt payment of claims by HMOs, to prohibit an HMO from retroactively denying a claim because of subscriber ineligibility at any time if the HMO verified the eligibility of a subscriber at the time of treatment and provided authorization number. Section 641.31(15), F.S. requires all health maintenance contracts to have a grace period of not less than 10 days. If any required premium is not paid on or before the due date, it may be paid during the following grace period. During the grace period, the contract stays in force. If full payment of the premium is not received by the end of the grace period, coverage terminates as of the grace period start date, and the HMO will retroactively deny the claim. Currently 641.3155, F.S., limits the ability of a HMO to deny a claim retroactively to one year after the date of payment of the claim. The bill would require HMOs to pay for such claims authorized during the grace period even if the subscriber did not pay the premium.

**Section 12** provides that the act will take effect October 1, 2015.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Implementation of the bill may provide health care providers with a greater number of drugs and treatments to meet the unique medical needs of their patients in a timelier manner.

Health care providers may experience less administrative costs associated with prior authorization protocols and formularies. One study estimated that prior authorization requests consumed about 20 hours a week per medical practice: 1 hour of the doctor's time, nearly 6 hours of clerical time, plus 13 hours of nurses' time.[29]

Insurers, managed care organizations, and health maintenance organizations may experience an indeterminate increase in costs to cover prescription drugs and other coverage limitations if the commission does not find sufficient clinical evidence to support coverage limitations imposed by the respective entity. Typically, step-therapy is applied to a certain drug class with the goal of encouraging generic drug use and decreasing costs. Those cost increases are likely to pass through to the purchasers of health insurance coverage, such as individuals and employers.

To the extent that step therapy policies and other coverage limitations contribute to increased costs from increased inpatient admissions and hospital emergency visits, the bill may serve to reduce those costs.

The posting of summary statements regarding coverage limitation by insurers and health maintenance organizations will provide greater transparency of information for consumers and health care providers.

The bill provides an October 1, 2015, effective date. According to the OIR, insurers are required to file their qualified health plan applications for new and old plans to be offered on the exchange by May 15, 2015, and such applications must be finalized by August 25, 2015.

The provisions of the bill would not apply to self-insured health plans since these plans are preempted from state regulation under the Employee Retirement Income Security Act of 1974. In Florida, approximately 60 percent of private-sector enrollees are enrolled in self-insured plans.

C. Government Sector Impact:

**Department of Health**

The cost to establish and operate the Clinical Practices Review Commission is indeterminate at this time.

[29] Theodore Karrison and Wendy Levinson, What Does It Cost Physician Practices To Interact With Health Insurance Plans? published online May 14, 2009, Health Affairs, 28, no.4 (2009):w533-w543 accessed at http://content.healthaffairs.org/content/28/4/w533.full (last visited March 2, 2015).

**Impact on Medicaid**

The fiscal impact to Medicaid is indeterminate. The bill requires the Clinical Practices Review Commission to determine whether sufficient clinical evidence exists for a proposed coverage limitation imposed by the insurer at the point of service. This provision of the bill will have an operational and fiscal impact on the Medicaid program. The bill does not limit the types of services or coverage limitations that would be subject to this requirement. Therefore, managed care plans would have to obtain approval from the commission for any limitation placed on a covered service – this could become administratively burdensome and duplicate processes that the plan has already established to monitor their utilization management program for clinical appropriateness. The Agency for Health Care Administration (agency) would also have to amend its contracts with the managed care plans to include this requirement.

To the extent that the commission disagrees with a coverage limitation, the managed care plan may incur additional expenses for providing services that are not medically necessary or for which an equally effective and less costly alternative treatment exists that can meet the needs of the enrollee.

SB 784 requires managed care plans serving MMA enrollees to provide a broad range of therapeutic options on their prescribed drug formulary or preferred drug list. Since managed care plans have not established their own plan-specific formulary or preferred drug list, this change would not result in a fiscal or operational impact to the Medicaid program, at this time.

According to the agency, the contracts with the Medicaid managed care plans have several quality and utilization management provisions to ensure enrollees receive medically necessary services in a timely manner. Requiring the commission to review all coverage limitations proposed by Medicaid managed care plans may also duplicate processes that the plans have already established to monitor their utilization management programs for clinical appropriateness.

**Division of State Group Insurance**

This bill would have a negative indeterminate fiscal impact to the State Employees' Health Insurance Trust Fund. Changes to current medical management procedures that cause an HMO's medical costs to increase could result in higher negotiated premiums for the state-contracted HMOs.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

If the bill becomes law, the Agency for Health Care Admiration states that it presents a potential conflict with Medicaid law.[30] Pursuant to 42 CFR 431.10, each state must "specify a single State agency established or designated to administer or supervise the administration of the plan." "The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State." The Agency for Health Care Administration is designated as the single state agency. As such, the agency is the final authority as to coverage and limitations related to Medicaid. Having other commissions or agencies determine coverage and limitations at the point of service would be contrary to Medicaid law and could possibly lead to a determination that is contrary to governing state and/or federal Medicaid law, the Medicaid managed care contract, the Medicaid State Plan, any governing federal Medicaid waivers. Thus, coverage limitations implemented by AHCA should be exempt from these requirements.

Section 627.6051(1), F.S., places liability on an insurer and its chief medical officer who uses a non-approved limitation. According to the Department of Management Services, the state group insurance program is protected by sovereign immunity because it is a program established by the State of Florida. Section 627.6051(1), F.S., does not specify whether the Legislature is waiving the program's sovereign immunity.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967, 627.642, 627.6471, 627.651, 627.662, 627.6699, 641.31, and 641.3155.

This bill creates the following sections of the Florida Statutes: 402.90 and 627.6051.

## 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 March 4, 2015:**
The CS provides the following changes:

- Clarifies that managed care plans may only establish coverage limitations that are supported by clinical evidence and the agency may not approve such coverage limitations without an assessment of the supporting evidence by the Clinical Services Review Commission.
- Defines the terms, "a coverage limitation imposed at the point of service" and "coverage limitation imposed by a health maintenance organization at the point of service."
- Prohibits an HMO from retroactively denying a claim because of subscriber ineligibility if the health maintenance organization verified the eligibility of a subscriber at the time of treatment and has provided an authorization number.

[30] Agency for Health Care Administration Bill Analysis (February 13, 2015) (on file with Banking and Insurance Committee).

- Requires each insurer to post a link to the list of preferred providers on the insurer's home page on the insurer's website and update the list within 10 days after any change in the list.

B. Amendments:

None.

**By** Senator Gaetz

1-00079B-15 2015784__

A bill to be entitled

An act relating to health care; providing that this act shall be known as the "Right Medicine, Right Time Act"; creating s. 402.90, F.S.; creating the Clinical Practices Review Commission; housing the commission, for administrative purposes, within the Division of Medical Quality Assurance of the Department of Health; specifying the composition of, qualifications for appointment to, and standards imposed on commission members; designating the members as public officers; requiring the executive director to submit to the Commission on Ethics a list of certain people subject to public disclosure requirements; providing penalties for failure to comply with such standards; specifying the duties and responsibilities of the commission; amending s. 409.967, F.S.; requiring a managed care plan that establishes a prescribed drug formulary or preferred drug list to provide a broad range of therapeutic options to the patient; requiring a managed care plan to comply with specified procedures; creating s. 627.6051, F.S.; requiring sufficient clinical evidence to support a proposed coverage limitation at the point of service; defining the term "sufficient clinical evidence"; requiring the commission to determine whether sufficient clinical evidence exists and the Office of Insurance Regulation to approve coverage limitations if the commission determines that such evidence exists; providing for the liability of a health insurer and its chief







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medical officer for injuries and damages resulting from restricted access to services if the insurer has imposed coverage limitations without the approval of the office; requiring insurers to establish reserves to pay for such damages; amending ss. 627.642 and 627.6699, F.S.; requiring an outline of coverage and certain plans offered by a small employer carrier to include summary statements identifying specific prescription drugs and procedures that are subject to specified restrictions and limitations; requiring insurers and small employer carriers to post the summaries on the Internet; amending s. 627.651, F.S.; conforming a cross-reference; amending s. 627.662, F.S.; specifying that specified provisions relating to coverage limitations on prescription drugs and diagnostic or therapeutic procedures apply to group health insurance, blanket health insurance, and franchise health insurance; amending s. 641.31, F.S.; requiring a health maintenance contract summary statement to include a statement of any limitations on benefits, the identification of specific prescription drugs, and certain procedures that are subject to specified restrictions and limitations; requiring a health maintenance organization to post the summaries on the Internet; prohibiting a health maintenance organization from establishing certain procedures and requirements that restrict access to covered services; exempting limitations that are supported by sufficient clinical evidence; requiring the commission to

evaluate the sufficiency of the evidence and the Office of Insurance Regulation to approve coverage limitations on the basis of the commission's evaluation; providing an effective date.

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

Section 1. This act shall be known as the "Right Medicine, Right Time Act."

Section 2. Section 402.90, Florida Statutes, is created to read:

402.90 Clinical Practices Review Commission.—There is created the Clinical Practices Review Commission, which is a commission as defined in s. 20.03.

(1) The commission shall be housed for administrative purposes in the Division of Medical Quality Assurance of the Department of Health.

(2) The commission shall consist of seven members appointed, subject to confirmation by the Senate, as follows:

(a) Five physicians, one appointed by the Governor, two appointed by the President of the Senate, and two appointed by the Speaker of the House of Representatives, who are currently practicing medicine in this state and have clinical expertise, as evidenced by the following:

1. A doctoral degree in medicine or osteopathic medicine from an accredited school;

2. An active and clear license issued by this state or another state;

3. Board certification in one or more medical specialties;





and

4. At least 15 years of clinical experience.

(b) One individual, appointed by the Governor, with a doctorate in either pharmacology or pharmacy and at least 10 years of experience in research or clinical practice with applicable postlicensure credentials.

(c) One member, appointed by the Governor, with expertise in the analysis of clinical research, evidenced by a doctoral degree in biostatistics or a related field and at least 10 years of experience in clinical research.

(3) A commission member may not currently be an officer, director, owner, operator, employee, or consultant of any entity subject to regulation by the commission. The executive director, senior managers, and members of the commission are subject to part III of chapter 112, including, but not limited to, the Code of Ethics for Public Officers and Employees and the public disclosure and reporting of financial interests pursuant to s. 112.3145. For purposes of applying part III of chapter 112 to the activities of the executive director, senior managers, and members of the commission, such persons shall be considered public officers or employees and the commission shall be considered their agency.

(a) Notwithstanding s. 112.3143(2), a commission member may not vote on any measure that would inure to his or her special private gain or loss; that he or she knows would inure to the special private gain or loss of any principal by whom he or she is retained, or to the parent organization or subsidiary of a corporate principal by which he or she is retained, other than an agency as defined in s. 112.312; or that he or she knows

would inure to the special private gain or loss of a relative or business associate of the public officer. A commission member who is prohibited from voting for such reasons shall publicly state to the assembly, before such a vote is taken, the nature of his or her interest in the matter from which he or she is abstaining from voting and, within 15 days after the vote, disclose the nature of his or her interest as a public record in a memorandum filed with the person responsible for recording the minutes of the meeting, who shall incorporate the memorandum in the minutes.

(b) Senior managers and commission members shall also file the disclosures required under paragraph (a) with the Commission on Ethics. The executive director of the commission or his or her designee shall notify each standing and newly appointed commission member and senior manager of his or her duty to comply with the reporting requirements of part III of chapter 112. At least quarterly, the executive director or his or her designee shall submit to the Commission on Ethics a list of names of the senior managers and members of the commission who are subject to the public disclosure requirements under s. 112.3145.

(c) Notwithstanding s. 112.3148, s. 112.3149, or any other law, an employee or member of the commission may not knowingly accept, directly or indirectly, any gift or expenditure from a person or entity, or an employee or representative of such person or entity, which has a contractual relationship with the commission or which is under consideration for a contract.

(d) An employee or member of the commission who fails to comply with this subsection is subject to the penalties provided





under ss. 112.317 and 112.3173.

(4) The duties and responsibilities of the commission include:

(a) Development and implementation of policies and procedures for the review of prior authorization, step therapy, or other protocols that limit, at the point of service, access to covered services, including diagnostic procedures, pharmaceutical services, and other therapeutic interventions.

(b) Development of any operational policies and procedures that would facilitate the work of the commission, including the establishment of bylaws, the election of a chair, and other administrative procedures.

(c) Determination as to the sufficiency of clinical evidence submitted in support of any proposed coverage limitation.

(d) Preparation of reports and recommendations that document the proceedings of the commission and identify necessary resources or legislative action.

(5) Subject to appropriations, a commission member may receive compensation and per diem and travel expenses as provided in s. 112.061.

Section 3. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2. A managed care plan that establishes a prescribed drug formulary or preferred drug list shall:

a. Provide a broad range of therapeutic options for the







treatment of disease states which are consistent with the general needs of an outpatient population. If feasible, the formulary or preferred drug list must include at least two products in each therapeutic class.

b.~~2.~~ ~~Each managed care plan must~~ Publish the ~~any~~ prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.

3. For enrollees ~~Medicaid recipients~~ diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

4.~~3.~~ Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

5.~~4.~~ Managed care plans serving children in the care and custody of the Department of Children and Families shall ~~must~~ maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to

provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department is ~~shall be~~ the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

6. Managed care plans shall comply with the procedures for approval of coverage limitations established pursuant to ss. 627.6051 and 641.31(44).

Section 4. Section 627.6051, Florida Statutes, is created to read:

627.6051 Required approval for certain coverage limitations.—

(1) A coverage limitation imposed by the insurer at the point of service must be supported by sufficient clinical evidence proving that the limitation does not inhibit timely diagnosis or effective treatment of the specific illness or condition for the covered patient. The term "sufficient clinical evidence" means:

(a) A body of research consisting of well-controlled studies conducted by independent researchers and published in peer reviewed journals or comparable publications which consistently support the treatment protocol or other coverage limitation as a best practice for the specific diagnosis or combination of presenting complaints.





(b) Results of a multivariate predictive model which indicate that the probability of achieving desired outcomes is not negatively altered or delayed by adherence to the proposed protocol.

(2) The Clinical Practices Review Commission established under s. 402.90 shall determine whether sufficient clinical evidence exists for a proposed coverage limitation imposed by the insurer at the point of service. In each instance in which the commission finds that sufficient clinical evidence exists to support a coverage limitation, the office shall approve the coverage limitation.

(3) If an insurer, without the approval of the office, imposes a coverage limitation at the point of service, including, but not limited to, a prior authorization procedure, step therapy requirement, treatment protocol, or other utilization management procedure that restricts access to covered services, the insurer and its chief medical officer shall be liable for any injuries or damages, as defined in s. 766.202, and economic damages, as defined in s. 768.81(1)(b), that result from the restricted access to services determined medically necessary by the physician treating the patient. An insurer that imposes such a coverage limitation at the point of service shall establish reserves sufficient to pay for such damages.

Section 5. Subsection (2) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

(2) The outline of coverage must ~~shall~~ contain:

(a) A statement identifying the applicable category of

coverage afforded by the policy, based on the minimum basic standards set forth in the rules issued to effect compliance with s. 627.643.

(b) A brief description of the principal benefits and coverage provided in the policy.

(c) A summary statement of the principal exclusions and limitations or reductions contained in the policy, including, but not limited to, preexisting conditions, probationary periods, elimination periods, deductibles, coinsurance, and any age limitations or reductions.

(d) A summary statement identifying specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol. The insurer shall post the summary statement at a prominent and readily accessible location on the Internet.

(e) A summary statement identifying any specific diagnostic or therapeutic procedures that are subject to prior authorization or other coverage limitations and the applicable coverage limitation policy or protocol. The insurer shall post the summary statement at a prominent and readily accessible location on the Internet.

(f) ~~(d)~~ A summary statement of the renewal and cancellation provisions, including any reservation of the insurer of a right to change premiums.

(g) ~~(e)~~ A statement that the outline contains a summary only of the details of the policy as issued or of the policy as applied for and that the issued policy should be referred to for the actual contractual governing provisions.







(h) ~~(f)~~ When home health care coverage is provided, a statement that such benefits are provided in the policy.

Section 6. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

627.651 Group contracts and plans of self-insurance must meet group requirements.—

(4) This section does not apply to any plan that ~~which~~ is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8) ~~627.662(7)~~. This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 7. Present subsections (7) through (14) of section 627.662, Florida Statutes, are redesignated as subsections (8) through (15), respectively, and a new subsection (7) is added to that section, to read:

627.662 Other provisions applicable.—The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(7) Section 627.642(2)(d) and (e), relating to coverage limitations on prescription drugs and diagnostic or therapeutic procedures.

Section 8. Paragraph (b) of subsection (12) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.—

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a high deductible plan that meets the requirements of a health savings account plan as defined by federal law or a health reimbursement arrangement as authorized by the Internal Revenue Service, which ~~that~~ meet the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan," "basic health benefit plan," and "high deductible plan" mean policies or contracts that a small employer carrier offers to eligible small employers which ~~that~~ contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; ~~and~~

b. A procedure for preauthorization or prior authorization by the small employer carrier, or its designees;

c. A summary statement identifying specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol. The carrier shall post the summary statement in a prominent and readily accessible location on the Internet; and

d. A summary statement identifying any specific diagnostic or therapeutic procedures subject to prior authorization or other coverage limitations and the applicable coverage





limitation policy or protocol. The carrier shall post the summary statement in a prominent and readily accessible location on the Internet.

3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the office, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to

small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for children with disabilities ~~handicapped children~~ pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan must ~~shall~~ include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan must ~~shall~~ place additional restrictions on the benefits and utilization and may also impose additional cost





containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding such ~~said~~ provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. The high-deductible ~~high deductible~~ plan associated with a health savings account or a health reimbursement arrangement must ~~shall~~ include all the benefits specified in subparagraph 4.

9. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association if ~~when~~ such services are available and the osteopathic hospital agrees to provide the service.

Section 9. Subsection (4) of section 641.31, Florida Statutes, is amended and subsection (44) is added to that section, to read:

641.31 Health maintenance contracts.—

(4) Each ~~Every~~ health maintenance contract, certificate, or member handbook must ~~shall~~ clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the benefits, services, or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity that ~~which~~ is underwriting any of the services offered by the health

maintenance organization. The contract, certificate, or member handbook must ~~shall~~ also state where and in what manner the comprehensive health care services may be obtained. The health maintenance organization shall prominently post the statement regarding limitations on benefits, services, or kinds of services provided on its website in a readily accessible location on the Internet. The statement must include, but need not be limited to:

(a) The identification of specific prescription drugs that are subject to prior authorization, step therapy, or any other coverage limitation and the applicable coverage limitation policy or protocol.

(b) The identification of any specific diagnostic or therapeutic procedures that are subject to prior authorization or other coverage limitations and the applicable coverage limitation policy or protocol.

(44) Health maintenance organizations and prepaid health plans are prohibited from establishing prior authorization procedures, step therapy requirements, treatment protocols, or other utilization management procedures that restrict access to covered services unless expressly authorized to do so under this subsection. A coverage limitation imposed by a health maintenance organization or prepaid health plan at the point of service must be supported by sufficient clinical evidence, as defined in s. 627.6051, which demonstrates that the limitation does not inhibit timely diagnosis or optimal treatment of the specific illness or condition for the covered patient.

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

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

784
*Bill Number (if applicable)*

Topic Health Care

*Amendment Barcode (if applicable)*

Name Corinne Mixon

Job Title Lobbyist

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*Street*

Phone 766-5755

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*City* *State* *Zip*

Email corinne@mixonassociates.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Academy of Physician Assistants

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

THE FLORIDA SENATE

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

SB 784
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Health Care

Name Georgia McKeown

Job Title Consultant

Address 113 E College Ave #303
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*City* *State* *Zip*

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Speaking: ☑ For ☐ Against ☐ Information

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

Representing American Cancer Society

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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THE FLORIDA SENATE

# APPEARANCE RECORD

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

3/4/2015
*Meeting Date*

748
*Bill Number (if applicable)*

Topic Health Care

*Amendment Barcode (if applicable)*

Name Alisa Lapolt

Job Title Gov Affairs

Address _____ Phone 850-443-1819
*Street*

_____ Email _____
*City* *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL Nurses Assn.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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THE FLORIDA SENATE

# APPEARANCE RECORD

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

Meeting Date

SB 784
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Right Medicine, Right Time

Name Ron Watson

Job Title lobbyist

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Tallahassee FL 32309
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Phone 850 567-1202

Email watson.strategies@comcast.net

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida CHAIN

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

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3-4-15
*Meeting Date*

184
*Bill Number (if applicable)*

Topic Health Care

*Amendment Barcode (if applicable)*

Name Jill Aran

Job Title Legislative Affairs Director

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*City* *State* *Zip*

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Email jill@fadaa.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Alcohol & Drug Abuse Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

3-4-2015 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 784

*Meeting Date* *Bill Number (if applicable)*

Topic HEALTHCARE

*Amendment Barcode (if applicable)*

Name BETH LABISKY

Job Title Consultant / Dir Govt Relations

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*City* *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against

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

Representing COPD FOUNDATION ALPHA 1 FOUNDATION

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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1:00 PM
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WAIVE TIME IN SUPPORT

THE FLORIDA SENATE

# APPEARANCE RECORD

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3-4-2015
*Meeting Date*

Topic HEALTH CARE

Bill Number SB 784 *(if applicable)*

Name STEPHEN R. WINN

Amendment Barcode _____ *(if applicable)*

Job Title EXECUTIVE DIRECTOR OF THE FOMA

Address 2007 APALACHEE PARKWAY *Street*

Phone 878-7364

TALLAHASSEE *City* FL *State* 32301 *Zip*

E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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**THE FLORIDA SENATE**

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3/4/15
*Meeting Date*

784
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Jason M. Goldman, MD

Job Title _____

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Coral Springs, FL 33065
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Phone 954-227-1234

Email goldmanmd@Bellsouth.net

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

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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**THE FLORIDA SENATE**

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3/4/15
*Meeting Date*

784
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Chris Niland

Job Title _____

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Jacksonville FL 32204
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Phone 904-233-3051

Email nilandlaw@aol.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Florida Neurosurgical Society / Florida Society of Thoracic and Cardiovascular Surgeons

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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**THE FLORIDA SENATE**

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3/4/15
*Meeting Date*

784
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Health Care

Name JACK McRAY

Job Title

Address 200 W. COLLEGE ST. #304 (*Street*)

Phone 850-577-5087

TLH FL 32301 (*City* / *State* / *Zip*)

Email jmcray@aarp.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

Topic _____ Bill Number 784 *(if applicable)*

Name Audrey Brown Amendment Barcode _____ *(if applicable)*

Job Title President + CEO

Address 200 W. College ave *Street* Phone 850-386-2904

Tallahassee *City* FL *State* 32301 *Zip* E-mail Audrey@FAHP.net

Speaking: ☐ For ☒ Against ☐ Information

Representing Florida Association of Health Plans

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

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

3-4-2015 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB784

*Meeting Date* *Bill Number (if applicable)*

Topic Health Insurance

*Amendment Barcode (if applicable)*

Name Joy Ryan

Job Title Shareholder

Address 325 W. College St. Phone 425-4000

*Street*

Tally 32312 Email joy@meenanlawfirm.com

*City* *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against

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

Representing America's Health Insurance Plans

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

UN

784
*Bill Number (if applicable)*

~~932076~~
*Amendment Barcode (if applicable)*

Topic _____

Name Paul Sanford

Job Title _____

Address 106 S. Monroe St
*Street*

Tallahassee, FL 32301
*City* *State* *Zip*

Phone 850-222-7200

Email _____

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Florida Blue - Florida Insurance Council

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

784
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic Health Care

Name Tammy Perdue

Job Title General Counsel

Address 516 N. Adams St
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Tallahassee FL 32301
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Phone 850-224-7173

Email tperdue@aif.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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THE FLORIDA SENATE

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

784
*Bill Number (if applicable)*

Topic Health Care / Patient Protection

*Amendment Barcode (if applicable)*

Name Greg Black

Job Title Attorney

Address 215 S. Monroe St, Ste 505
*Street*

Phone 205-9000

TLH FL 32301
*City* *State* *Zip*

Email greg.black@metzlaw.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing BioFlorida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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THE FLORIDA SENATE

# APPEARANCE RECORD

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

March 4, 15
*Meeting Date*

784
*Bill Number (if applicable)*

Topic Step Therapy / Prior Auth

*Amendment Barcode (if applicable)*

Name Pam Freeman MD

Job Title MD

Address 1427 Buckwood Drive
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Phone 407-222-3603

Orlando Florida 32806
*City* *State* *Zip*

Email ~~Pamrheu~~ Pamrheu@aol.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.***

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

Topic Right Medicine, Right Time Act

Bill Number 784 *(if applicable)*

Name Jesse Fry

Amendment Barcode _____ *(if applicable)*

Job Title State Policy Analyst

Address 641 E. College Ave. Unit 2
*Street*

Tallahassee FL 32301
*City* *State* *Zip*

Phone (850) 339-6395

E-mail jfry@theaidsinstitute.org

Speaking: ☒ For ☐ Against ☐ Information

Representing The AIDS 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 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3-4-15
*Meeting Date*

Topic _____ Bill Number 784 *(if applicable)*

Name Charlean M Lanier Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 74 Greenlea Circle Phone 850-284-4637

*Street*

Crawfordville FL 32327 E-mail harvestfoodmin@yahoo.com

*City* *State* *Zip*

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

Representing Patient Advocate

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 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

Topic Right Medicine, Right Time Act

Bill Number 784 *(if applicable)*

Name Pam Langford

Amendment Barcode *(if applicable)*

Job Title President

Address PO Box 180513 *Street*

Phone

Tallahassee FL 32318
*City* *State* *Zip*

E-mail

Speaking: ☒ For ☐ Against ☐ Information

Representing HEALS of the South

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)

3/4/15
*Meeting Date*

Topic Right Medicine, Right Time Act

Bill Number 784 *(if applicable)*

Name Chris Wells

Amendment Barcode *(if applicable)*

Job Title Representative

Address 1336 Vickers Rd.
*Street*

Tallahassee FL 32303
*City* *State* *Zip*

Phone (850)222-2355

E-mail Chris@sicklecellfoundation.org

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

Representing Sickle Cell Foundation

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 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

Topic Right Medicine, Right Time Act

Bill Number 784 *(if applicable)*

Name Anne Swerlick

Amendment Barcode _____ *(if applicable)*

Job Title Deputy Director of Advocacy

Address 2425 Torreya Dr.
*Street*

Phone _____

Tallahassee FL 32303
*City* *State* *Zip*

E-mail _____

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

Representing Florida Legal Services

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

Lobbyist registered with Legislature: [X] 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 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3-4-15
*Meeting Date*

SB-784
*Bill Number (if applicable)*

*Amendment Barcode (if applicable)*

Topic "Right Medicine Right Time"

Name Marnie George

Job Title Govt. Affairs

Address 101 S. Monroe
*Street*

Tallahassee FL 32301
*City* *State* *Zip*

Phone 850-510-8866

Email marnie.george

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL. Chapter Am College of Cardiology

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 522 |
| INTRODUCER: | Senator Brandes |
| SUBJECT: | Division of Bond Finance |
| DATE: | March 3, 2015 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | McVaney | McVaney | GO | **Favorable** |
| 2. | Matiyow | Knudson | BI | **Favorable** |
| 3. | | | FP | |

## I. Summary:

SB 522 deletes the requirement that the Division of Bond Finance housed within the State Board of Administration publish a subscription based newsletter to various stakeholders regarding local and state bonds. Due to the lack of subscribers, the last issue of the newsletter was published by the Division in the fall of 2000.

## II. Present Situation:

The Division of Bond Finance (Division) was created in the State Bond Act[1] (Act) in 1969 and is administratively housed within the State Board of Administration.[2] The Governor serves as chair of the governing board of the Division, the Attorney General is the secretary, and the Chief Financial Officer acts as treasurer.[3]

The Division is responsible for issuing any state bonds authorized by law or the Florida Constitution, as well as bonds on behalf of any state agency authorized by law.[4] As it is used in the Act, a state agency is defined as "any board, commission, authority, or other state agency heretofore or hereafter created by the constitution or statutes of the state."[5] In carrying out its authority, the Division is authorized to exercise all of the powers relating to bonds to the same extent as state agencies.[6]

[1] The State Bond Act encompasses ss. 215.57-215.83, F.S.
[2] Section 215.62(1), F.S.
[3] *Id.*
[4] Section 215.64(2), F.S.
[5] Section 215.58(6), F.S.
[6] Section 215.64(3), F.S.

As part of its duties, the Division serves as a clearinghouse of information relating to both general obligation bonds and revenue bonds of the state and local governments.[7] The Division is required to collect, maintain, and make available information concerning such bonds.[8] The Division also is required to issue a regular newsletter containing information of interest relating to these bonds to issuers, underwriters, attorneys, investors, and other parties within the bond community, as well as to the general public.[9] The Division is authorized to charge fees for subscriptions to the newsletter.[10]

The Division's newsletter does not have any subscribers. As a result, the Division has not published an issue of the newsletter since the fall of 2000. The Division has never charged a fee for the newsletter.

## III. Effect of Proposed Changes:

The bill deletes the requirement for the Division to issue a regular newsletter containing information of interest relating to local and state bonds to issuers, underwriters, attorneys, investors, other parties within the bond community, and the general public.

This bill takes effect July 1, 2015.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The bill does not require counties or municipalities to take an action requiring a significant expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, or reduce the percentage of state tax shared with counties or municipalities.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[7] Section 218.37, F.S.
[8] Section 218.37(1)(a)-(c), F.S.
[9] Section 218.37(1)(f), F.S.
[10] *Id.*

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 218.37 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

22-00878-15 2015522__

A bill to be entitled

An act relating to the Division of Bond Finance; amending s. 218.37, F.S.; deleting a requirement that the division issue a regular newsletter to certain parties which addresses local and state bonds; providing an effective date.

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

Section 1. Paragraph (f) of subsection (1) of section 218.37, Florida Statutes, is amended to read:

218.37 Powers and duties of Division of Bond Finance; advisory council.—

(1) The Division of Bond Finance of the State Board of Administration, with respect to both general obligation bonds and revenue bonds, shall:

~~(f) Issue a regular newsletter to issuers, underwriters, attorneys, investors, and other parties within the bond community and the general public containing information of interest relating to local and state bonds. The division may charge fees for subscriptions to the newsletter.~~

Section 2. This act shall take effect July 1, 2015.

799500

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 03/04/2015 | . | |
| | . | |
| | . | |
| | . | |

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

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause and insert:

Section 1. Section 629.271, Florida Statutes, is amended to read:

629.271 Distribution of savings.—

(1) A reciprocal insurer may ~~from time to time~~ return to its subscribers any unused premiums, savings, or credits accruing to their accounts. ~~Any~~ Such distribution may ~~shall~~ not

799500

unfairly discriminate between classes of risks~~,~~ or policies, or between subscribers, but ~~such distribution~~ may vary as to classes of subscribers based on ~~upon~~ the experience of the ~~such~~ classes.

(2) In addition to the option provided in subsection (1), a domestic reciprocal insurer may, upon the prior written approval of the office, pay to its subscribers a portion of unassigned funds of up to 10 percent of surplus with distribution limited to 50 percent of net income from the previous calendar year. Such distribution may not unfairly discriminate between classes of risks or policies, or between subscribers, but may vary as to classes of subscribers based on the experience of such classes.

Section 2. This act shall take effect July 1, 2015.

========== 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 reciprocal insurers; amending s. 629.271, F.S.; authorizing domestic reciprocal insurers to return a portion of unassigned funds to their subscribers; providing limitations; providing an effective date.

**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 678 |
| INTRODUCER: | Banking and Insurance Committee and Senator Diaz de la Portilla |
| SUBJECT: | Reciprocal Insurers |
| DATE: | March 4, 2015 |
| REVISED: | |

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

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 678 creates an additional process for a domestic reciprocal insurer to distribute to policyholders unassigned funds such as unused premiums, savings, and credits. The process created by the bill differs from current law primarily by not requiring the reciprocal insurer to create subscriber accounts to make distributions to policyholders. Distributions using this method may not exceed 50 percent of the insurer's net income from the previous calendar year and may be up to 10 percent of the insurer's surplus.

## II. Present Situation:

A reciprocal insurance company is an unincorporated group of subscribers who exchange risk, with each member serving both as the insurer and insured.[1] The subscribers operate through an attorney in fact to provide reciprocal insurance among themselves.[2] Reciprocal insurers may transact any line of insurance other than life or title. Reciprocal insurers are not common and primarily write motor vehicle insurance.[3] Two of the larger reciprocal insurance companies are Farmers Insurance and United Services Automobile Association (USAA). In Florida, authorized reciprocal insurers are governed by the provisions of ch. 629 of the Florida Statutes.

[1] Robert W. Klein, *A Regulator's Introduction to the Insurance Industry*, 5-4 (National Association of Insurance Commissioners 1999).
[2] Section 629.021, F.S.
[3] See fn. 1.

A domestic reciprocal insurer may be organized by 25 or more persons domiciled in Florida, provided the reciprocal is formed in accordance with the requirements of ch. 629, Florida Statutes, and is approved by the Office of Insurance Regulation.[4] The reciprocal insurer must have a subscribers' advisory committee with powers set forth in the subscribers' agreement. These powers must include supervising the finances of the insurer, supervising the insurer's operations to assure conformity with the subscribers' agreement and power of attorney, and procuring the audit of the accounts and records of the insurer and the attorney in fact.
Section 629.274, F.S., governs the distribution of savings from reciprocal insurers to their subscribers. Reciprocal insurers may distribute to subscribers unused premiums, savings, or credits accruing to their subscriber savings accounts. Distributions may not unfairly discriminate between classes of risks, or policies, or between subscribers but may vary as to classes of subscribers based up on the experience of such subscriber classes.

The Internal Revenue Code provides that a reciprocal insurer may claim a deduction from taxable income for amounts that are added to subscriber savings accounts.[5] For an insurer to claim the deduction, the amounts in subscriber savings accounts must be immediately payable to the subscriber at the end of the taxable year if the subscriber ends his or her account. The credit to the subscriber account are considered a paid or declared dividend by the subscriber.

## III. Effect of Proposed Changes:

CS/SB 678 amends s. 629.271, F.S., to create an additional process for a domestic reciprocal insurer to distribute to policyholders unassigned funds such as unused premiums, savings, and credits. The process created by the bill differs from current law primarily by not requiring the reciprocal insurer to create subscriber accounts to make distributions to policyholders. Only domestic reciprocal insurers may use the distribution process created by the bill.
The new policyholder distribution process created by the bill instead creates limits on the total amount of distributions if subscriber accounts are not used and also subjects such distributions to Office of Insurance Regulation approval. The distribution may not exceed 50 percent of the insurer's net income from the previous calendar year and may be up to 10 percent of the insurer's surplus. As under current law for distributions using subscriber accounts, distributions using this method may not unfairly discriminate between classes of risks, policies, or subscribers.

The effective date of the bill is July 1, 2015.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[4] See section 629.081, F.S.
[5] 26 U.S.C. 832(f).

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

A domestic reciprocal insurer may save administrative costs by using the distribution method created by this bill rather than establishing and maintaining subscriber savings accounts. The method created by this bill will create savings for those domestic reciprocal insurers for whom the federal tax deduction for monies placed in a subscriber savings accounts is exceeded by the administrative savings of using the procedure created by this bill.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 629.271 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 March 4, 2015:**
The CS provides that only domestic reciprocal insurers may use the subscriber distribution method created by the bill.

B. Amendments:

None.

**By** Senator Diaz de la Portilla

40-00953-15 2015678__

A bill to be entitled

An act relating to reciprocal insurers; amending s. 629.271, F.S.; authorizing a reciprocal insurer to distribute a portion of unassigned funds up to a specified limit if approved by the Office of Insurance Regulation; providing that such distribution may not unfairly discriminate between classes of risks or policies or between subscribers; providing an effective date.

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

Section 1. Section 629.271, Florida Statutes, is amended to read:

629.271 Distribution of savings.—

(1) A reciprocal insurer may distribute ~~from time to time return~~ to its subscribers:

(a) Any unused premiums, savings, or credits accruing to the subscribers' ~~their~~ accounts.

(b) A portion of unassigned funds, which may be up to 10 percent of the surplus, if such distribution is approved in writing by the office and does not exceed 50 percent of net income from the previous calendar year.

(2) A ~~Any such~~ distribution under this section may ~~shall~~ not unfairly discriminate between classes of risks, or policies, or between subscribers, but ~~such distribution~~ may vary as to classes of subscribers based upon the experience of such classes.

Section 2. This act shall take effect July 1, 2015.

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

678

*Meeting Date* | *Bill Number (if applicable)*

Topic Reciprocal

*Amendment Barcode (if applicable)*

Name Sean Stafford

Job Title

Address 115 E. Park

*Street*

Phone

*City* *State* *Zip*

Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against

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

Representing Star d Shield Insurance Group

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)

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 03/04/2015 | . | |
| | . | |
| | . | |
| | . | |

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

**Senate Amendment (with title amendment)**

Delete lines 139 - 140
and insert:
the office's authority to investigate any entity to ensure that it is not in violation of this chapter or applicable provisions of the

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

117136

Delete lines 11 - 12

and insert:

investigate any entity to ensure that it is not in violation of ch. 662, F.S., or applicable provisions of the financial

118860

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 03/04/2015 | . | |
| | . | |
| | . | |
| | . | |

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

**Senate Amendment (with title amendment)**

Delete lines 185 - 207

and insert:

Section 7. Subsection (2) of section 662.1225, Florida Statutes, is amended, and subsection (3) is added to that section, to read:

662.1225 Requirements for a family trust company, licensed family trust company, and foreign licensed family trust company.—

118860

(2) In order to operate in this state, a foreign licensed family trust company must be in good standing in its principal jurisdiction, must be in compliance with the family trust company laws and regulations of its principal jurisdiction, and must maintain:

(a) An office physically located in this state where original or true copies of all records and accounts of the foreign licensed family trust company pertaining to its operations in this state may be accessed and made readily available for examination by the office in accordance with this chapter.

(b) A registered agent who has an office in this state at the street address of the registered agent.

(c) All applicable state and local business licenses, charters, and permits.

(d) A deposit account with a state-chartered or national financial institution that has a principal or branch office in this state.

(3) A company in operation as of October 1, 2015, which meets the definition of a family trust company, must, on or before December 30, 2015, apply for licensure as a licensed family trust company, register as a family trust company or foreign licensed family trust company, or cease doing business in this state.

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

And the title is amended as follows:

Delete line 24

and insert:

118860

in its jurisdiction; specifying the date upon which family trust companies must be registered or licensed or, if not registered or licensed, cease doing business in this state; amending s. 662.123, F.S.;

704630

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 03/04/2015 | . | |
| | . | |
| | . | |
| | . | |

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

**Senate Amendment (with title amendment)**

Delete lines 274 - 276
and insert:
Section 10. Subsections (4) and (7) of section 662.132, Florida Statutes, are amended to read:
662.132 Investments.—
(4) Notwithstanding any other law, a family trust company or licensed family trust company may, while acting as a fiduciary, purchase directly from underwriters or broker-dealers

704630

~~distributors~~ or in the secondary market:

(a) Bonds or other securities underwritten or brokered ~~distributed~~ by:

1. The family trust company or licensed family trust company;

2. A family affiliate; or

3. A syndicate, including the family trust company, licensed family trust company, or family affiliate.

(b) Securities of an investment company, including a mutual fund, closed-end fund, or unit investment trust, as defined under the federal Investment Company Act of 1940, for which the family trust company or licensed family trust company acts as an advisor, custodian, distributor, manager, registrar, shareholder servicing agent, sponsor, or transfer agent.

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

And the title is amended as follows:

Between lines 30 and 31

insert:

revising the authority of specified family trust companies while acting as fiduciaries to purchase certain bonds and securities;

437510

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 03/04/2015 | . | |
| | . | |
| | . | |
| | . | |

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

**Senate Amendment (with title amendment)**

Delete lines 305 - 315

and insert:

may conduct an examination or investigation of a ~~family trust company,~~ licensed family trust company~~, or foreign licensed family trust company~~ at any time it deems necessary to determine whether the ~~a family trust company,~~ licensed family trust company~~, foreign licensed family trust company,~~ or licensed family trust company-affiliated party thereof ~~person~~ has

437510

violated or is about to violate any provision of this chapter, ~~or rules adopted by the commission pursuant to this chapter, or~~ any applicable provision of the financial institution codes, or any rule ~~rules~~ adopted by the commission pursuant to this chapter or the ~~such~~ codes. The office may conduct an examination or investigation of a family trust company or foreign licensed family trust company at any time it deems necessary to determine whether the family trust company or foreign licensed family trust company has engaged in any act prohibited under s. 662.131 or s. 662.134 and, if a family trust company or a foreign licensed family trust company has engaged in such act, to determine whether any applicable provision of the financial institution codes has been violated.

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

And the title is amended as follows:

Delete line 33

and insert:

companies; amending s. 662.141, F.S.; revising the purposes for which the office may examine or investigate a family trust company that is not licensed and a foreign licensed family trust company; deleting the

612190

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 03/04/2015 | . | |
| | . | |
| | . | |
| | . | |

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

**Senate Amendment (with title amendment)**

Between lines 458 and 459
insert:

Section 14. Section 662.144, Florida Statutes, is amended to read:

662.144 Failure to submit required report; fines.—If a family trust company, licensed family trust company, or foreign licensed family trust company fails to submit within the prescribed period its annual renewal or any other report

612190

required by this chapter or any rule, the office may impose a fine of up to $100 for each day that the annual renewal or report is overdue. Failure to provide the annual renewal within 60 days after the end of the calendar year shall automatically result in termination of the registration of a family trust company or foreign licensed family trust company or revocation of the license of a licensed family trust company. A family trust company may have its registration or license automatically reinstated by submitting to the office, on or before August 31 of the calendar year in which the renewal application is due, the company's annual renewal application and fee required under s. 662.128, a $500 late fee, and the amount of any fine imposed by the office under this section. A family ~~The~~ trust company that fails to renew or reinstate its registration or license must ~~shall thereafter have 90 days to~~ wind up its affairs on or before November 30 of the calendar year in which such failure occurs. Fees and fines collected under this section shall be deposited into the Financial Institutions' Regulatory Trust Fund pursuant to s. 655.049 for the purpose of administering this chapter.

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

And the title is amended as follows:

Delete line 54

and insert:

parties; amending s. 662.144, F.S.; authorizing a family trust company to have its terminated registration or revoked license reinstated under certain circumstances; revising the timeframe for a

612190

family trust company to wind up its affairs under certain circumstances; requiring the deposit of certain fees and fines in the Financial Institutions' Regulatory Trust Fund; amending s. 662.145, F.S.; revising the

957628

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 03/04/2015 | . | |
| | . | |
| | . | |
| | . | |

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

**Senate Amendment (with title amendment)**

Delete lines 503 - 509

and insert:

~~(3) A company in operation as of the effective date of this act that meets the definition of a family trust company shall have 90 days from the effective date of this act to apply for licensure as a licensed family trust company, register as a family trust company or foreign licensed family trust company, or cease doing business in this state.~~

957628

========== T I T L E  A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 59 - 60
and insert:
s. 662.150, F.S.; making a technical change; amending
s. 662.151, F.S.; conforming a provision to changes
made by the act; providing an effective date.

**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 568 |
| INTRODUCER: | Banking and Insurance Committee and Senator Richter |
| SUBJECT: | Family Trust Companies |
| DATE: | March 4, 2015 |
| REVISED: | |

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

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 568 amends the Florida Family Trust Company Act. Chapter 662, F.S., was created in 2014 to allow families to form and operate private or family trust companies that provide trust services similar to those that can be provided by an individual trustee or a financial institution. Family trust companies are owned exclusively by family members and may not provide fiduciary services to the public. These private, family trust companies are generally formed to manage the wealth of high net-worth families in lieu of traditional individual or institutional trustee arrangements for a variety of personal, investment, regulatory, and tax reasons.

Chapter 662, F.S., authorized the creation of three types of family trust companies: licensed family trust companies, foreign family trust companies, and unlicensed family trust companies. This bill amends ch. 662, F.S., to:

- Provide that the office must conduct an examination of a licensed family trust company every 36 months instead of the current 18 months. The bill does not allow an audit to substitute for an examination conducted by the office;
- Remove the requirement that the office conduct examinations of unlicensed family trust companies;
- Require that a court determine there has been a breach of fiduciary duty or trust before the Office of Financial Regulation ("OFR" or "the office") may enter a cease and desist order;
- Require all family trust companies in operation on October 1, 2015, to either apply for licensure as a licensed family trust company, register as a family trust company, register as a

foreign licensed family trust company, or cease doing business in this state by December 30, 2015.

- Make legislative findings that clarify that the OFR is responsible for the regulation, supervision, and examinations of licensed family trust companies but that for unlicensed or foreign family trust companies the role of the OFR is limited to ensuring that services provided by such companies are provided only to family members and not to the general public;
- Require the management of a licensed family trust company to have at least three directors or managers and require that at least one of those directors or managers be a Florida resident;
- Provide that a family trust company registration application must state that trust operations will comply with statutory provisions relating to requirements in organizational documents and relating to minimum capital requirements;
- Provide that the designated relatives in a licensed family trust company may not have a common ancestor within three generations instead of the current five generations;
- Require that a registration application for a foreign licensed family trust company must provide proof that the company is in compliance with the family trust company laws and regulations of its principal jurisdiction;
- Require amendments to certificates of formation or certificates of organization to be submitted to the OFR at least 30 days before it is filed or effective;
- Create a mechanism for automatic reinstatement of lapsed licenses and registrations by payment of appropriate fees and any fines imposed by the OFR; and
- Allow family trust companies, licensed family trust companies, and foreign licensed family trust companies to file annual renewal applications within 45 days of the end of each calendar year.

## II. Present Situation:

### The Family Trust Company

A family trust company provides trust services to a related group of people and cannot provide services to the general public. This includes serving as a trustee of trusts held for the benefit of the family members, as well as providing other fiduciary, investment advisory, wealth management, and administrative services to the family. A family might wish to form a family trust company in order to keep family matters more private than they would be if turned over to an independent trustee, to gain liability protection, to establish its own trust fee structure, and to obtain tax advantages. Traditional trust companies require regulatory oversight, licensing of investment personnel, public disclosure and capitalization requirements considered by practitioners to be overbroad and intrusive for the family trust.

In 2014, the Legislature authorized the creation of family trust companies in Florida.[1] The legislation takes effect on October 1, 2015.[2] At least 14 other states currently have statutes governing the organization and operation of family trust companies.

[1] *See* ch. 2014-97, L.O.F.
[2] *Id*.

**Types of Family Trust Companies**

Chapter 662, F.S., creates three types of family trust companies: family trust companies, licensed family trust companies, and foreign licensed family trust companies.[3] A "family trust company" is a corporation or limited liability company (LLC) that is exclusively owned by one or more family members, is organized or qualified to do business in Florida, acts or proposes to act as a fiduciary to serve one or more family members, and does not serve as a fiduciary for a person, entity, trust, or estate that is not a family member, except that it may serve as a fiduciary for up to 35 individuals who are not family members if the individuals are current or former employees of the family trust company or one or more trusts, companies, or other entities that are family members.[4]

A "licensed family trust company" means a family trust company that operates in accordance with this chapter and has been issued a license that has not been revoked or suspended by the OFR.[5]

A "foreign licensed family trust company" means a family trust company that is licensed by a state other than Florida, has its principal place of business in a jurisdiction in the United States other than Florida, is operated in accordance with family or private trust company laws of a jurisdiction other than Florida, and is subject to statutory or regulatory mandated supervision by the jurisdiction in which the principal place of business is located.[6]

**Powers of a Family Trust Company**

Section 662.130, F.S., provides that a family trust company and a licensed family trust company may:

- Act as a sole or copersonal representative, executor, or curator for probate estates being administered in a state or jurisdiction other than Florida.
- Act as an attorney-in-fact or agent under a power of attorney, other than a power of attorney governed by ch. 709, F.S.
- Act within or outside of Florida as sole fiduciary or cofiduciary and possess, purchase, sell, invest, reinvest, safekeep, or otherwise manage or administer the real or personal property of eligible individuals and members.
- Exercise the powers of a corporation or LLC incorporated or organized under Florida law, or qualified to transact business as a foreign corporation or LLC under Florida law, which are reasonably necessary to enable it to fully exercise, in accordance with commonly accepted customs and usages, a power conferred by the Florida Family Trust Company Act.
- Delegate duties and powers, including investment functions under s. 518.112, F.S., in accordance with the powers granted to a trustee under ch. 736, F.S., or other applicable law, and retain agents, attorneys, accountants, investment advisers, or other individuals or entities to advise or assist the family trust company, licensed family trust company, or foreign licensed family trust company in the exercise of its powers and duties.

[3] Chapter 662, F.S., was created by 2014-97, L.O.F.
[4] *See* s. 662.111(12), F.S.
[5] *See* s. 662.111(16), F.S.
[6] *See* s. 662.111(15), F.S.

- Perform all acts necessary for exercising these powers.

**Capital Requirements**

Section 662.124, F.S., provides minimum capital requirements. A family trust company or a licensed family trust company may not be organized with an owners' capital account of less than $250,000.

**Licensed Family Trust Companies**

Section 662.121, F.S., requires a company wishing to be licensed as a licensed family trust company to file an application with the OFR. When a company files an application for licensure as a licensed family trust company, s. 662.1215, F.S., requires the OFR to conduct an investigation to confirm that persons who will serve as directors or officers of the corporation or, if the applicant is a LLC, managers or members acting in a managerial capacity, have not:

- Been convicted of, or entered a plea of nolo contendere to, a crime involving fraud, misrepresentation, or moral turpitude.
- Been convicted of, or pled nolo contendere to, a violation of the financial institutions codes or similar state or federal laws.
- Been directors or executive officers of a financial institution licensed or chartered under the financial institutions codes or by the Federal Government or any other state, the District of Columbia, a territory of the United States, or a foreign country, whose license or charter was suspended or revoked within the 10 years preceding the date of the application.
- Had a professional license suspended or revoked within 10 years preceding the application.
- Made a false statement of material fact on the application.

The OFR must also confirm that the name of the proposed company complies with naming requirements, that capital accounts of the proposed company conform to relevant law, that the fidelity bonds and errors and omissions insurance coverage required are issued and effective, and that the articles of incorporation or articles of organization conform to applicable law. If the OFR determines the application does not meet statutory criteria, it must issue a notice of intent to deny the application and offer the applicant an opportunity for an administrative hearing.[7]

**Management of Family Trust Companies**

Section 662.125, F.S., provides that exclusive authority to manage a licensed family trust company is vested in a board of directors, if a corporation, or a board of directors or managers, if a limited liability company. A licensed family trust company must have at least three directors or managers and at least one director or manager of the company must be a resident of this state.

**Renewal of Licensure or Registration**

Section 662.128, F.S., requires family trust companies, licensed family trust companies, and foreign licensed family trust companies to file renewal applications with the OFR within 30 days after the end of each calendar year.

[7] *See* s. 662.1215(4), F.S.

**Examinations and Investigations by the OFR**

Section 662.141, F.S., provides that the office may conduct an examination or investigation of a family trust company, licensed family trust company, or foreign licensed family trust company at any time it deems necessary to determine whether a family trust company, licensed family trust company, or foreign licensed family trust company has violated or is about to violate any provision of ch. 662, F.S., any relevant administrative rules, or any applicable provision of the financial institution codes. Section 662.141(1), F.S., requires the office to conduct an examination of a licensed family trust company, family trust company, and foreign licensed family trust company at least once every 18 months. The office may accept an audit in lieu of conducting an entire examination in certain circumstances.[8]

There is concern among practitioners that the current regulatory scheme in ch. 662, F.S., does not allow licensed family trust companies to qualify for the "bank exemption" with the federal Securities and Exchange Commission.[9] If these companies do not qualify for the "bank exemption," they will be required to register as investment advisers with the federal regulator.[10]

**Cease and Desist Authority**

Section 662.143, F.S., gives the OFR the power to order a family trust company, licensed family trust company, or foreign licensed family trust company to cease and desist from engaging in specified activities or practices. If the OFR believes there could be a violation, it must give the entity notice of the violation and an opportunity for an administrative hearing.[11] One of the specific practices that the OFR can take action against is if it has reason to believe that a family trust company, licensed family trust company, or foreign licensed family trust company is engaging in or has engaged in an act of commission or omission or a practice that is a breach of trust or of fiduciary duty.

## III. Effect of Proposed Changes:

**Section 1** of this bill amends the findings to clarify that the OFR is responsible for the regulation, supervision, and examinations of licensed family trust companies but that the office's role is limited to ensuring that services provided by unlicensed or foreign family trust companies are provided to family members and not to the general public.

**Changes to Licensed Family Trust Companies**

**Section 5** of the bill amends s. 662.1215, F.S., to include within the OFR initial licensure investigation of an applicant seeking to be recognized as a licensed family trust company, verification that the management of a licensed family trust company complies with s. 662.125, F.S. Section 662.125, F.S., requires a family trust company or licensed family trust company to

[8] *See* s. 662.141(2), F.S.
[9] *See* Real Property, Probate, and Trust Law Section of the Florida Bar White Paper on Proposed Changes to the Florida Family Trust Company Act (on file with Committee on Banking and Insurance Committee staff).
[10] *Id*.
[11] *See* s. 662.143(2), F.S.

have at least three directors or managers and requires that at least one of those directors or managers be a Florida resident.

**Section 11** of this bill amends s. 662.141, F.S., to provide that the office must conduct an examination of a licensed family trust company every 36 months instead of the current 18 months. The bill does not allow an audit to substitute for an examination conducted by the office.

**Section 12** of this bill amends s. 662.142, F.S., to clarify that a licensed family trust company is entitled to an administrative hearing pursuant to ch. 120, F.S., to contest a license revocation.

**Changes to Unlicensed Family Trust Companies**

**Section 6** of this bill provides that a family trust company registration application must state that its operations will comply with s. 662.123(1), F.S. (relating to requirements in organizational documents) and s. 662.124, F.S. (relating to minimum capital requirements).

**Section 11** of this bill removes the requirement that the office conduct examinations of unlicensed family trust companies. The OFR may conduct examinations of such entities at any time it deems necessary.

**Other Provisions of the Bill**

**Section 2** makes a technical change to the definition of "officer."

**Section 3** provides that the financial institutions codes do not apply to family trust companies, licensed family trust companies, or foreign family trust companies unless specifically made applicable by ch. 662, F.S., in order to make ch. 662 a stand-alone statute for family trust companies. It further provides that this does not limit the office's power to investigate any entity to determine compliance with ch. 662 or applicable provisions of the financial institutions codes.

**Section 4** of this bill provides that the designated relatives in licensed family trust company may not have a common ancestor within three generations instead of the current five generations.[12]

**Section 6** of this bill requires that a registration application for a foreign licensed family trust company must provide proof that the company is in compliance with the family trust company laws and regulations of its principal jurisdiction.

**Section 7** of this bill requires a foreign licensed family trust company to be in compliance with the laws of its principal jurisdiction in order to operate in Florida. The bill requires all family trust companies in operation on October 1, 2015, to either apply for licensure as a licensed family trust company, register as a family trust company, register as a foreign licensed family trust company, or cease doing business in this state. The application or registration must be filed by December 30, 2015.

[12] "Designated relative" means a common ancestor of a family, who may be a living or deceased person, and who is so designated in the application for a license.

**Section 8** of this bill requires amendments to certificates of formation or certificates of organization to be submitted to the OFR at least 30 days before it is filed or effective. It removes the requirement that bylaws or articles of organization be submitted to this OFR.

**Section 9** of the bill allows family trust companies, licensed family trust companies, and foreign licensed family trust companies to file annual renewal applications within 45 days of the end of each calendar year. Current law allows 30 days. This bill also requires a family trust company registration renewal application to certify compliance with capital requirements and statutes relating to organizational documents.

**Section 10** of the bill removes references to the term "affiliate" and replaces it with "parent" or "subsidiary company" in s. 662.132, F.S., to prevent confusion with the term "family affiliate" defined in s. 662.111, F.S. It also provides that a family trust company or licensed family trust company may purchase bonds and securities directly from broker-dealers when acting as a fiduciary.

**Section 13** of this bill allows the OFR to serve a complaint against a family trust company, licensed family trust company, or foreign licensed family trust company if a court has determined that there has been a breach of trust or fiduciary duty.

**Section 14** of this bill provides a mechanism to reinstate the license or registration of a family trust company, licensed family trust company, or foreign licensed family trust company that was terminated for failure to timely file an annual renewal. The bill provides that a family trust company may have its license or registration automatically reinstated by submitting the renewal application, renewal fee, late fee, and any fine imposed by the OFR.

**Sections 15 and 16** of this bill make technical changes.

**Section 17** of this bill repeals s. 662.151(3), F.S. The bill transfers this provision of law to s. 662.1225, F.S.

**Section 18** of this bill provides an effective date of October 1, 2015.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill's proponents expect that as a result of this legislation, high net worth families who are not located in Florida may select Florida as the jurisdiction to establish FTCs, which may benefit the investment, accounting, legal and advisory support services for these FTCs and family businesses.[13]

C. Government Sector Impact:

The OFR does not anticipate a fiscal impact on state government.[14]

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 662.102, 662.111, 662.120, 662.1215, 662.122, 662.1225, 662.123, 662.128, 662.132, 662.141, 662.142, 662.143, 662.145, 662.150, and 662.151.

This bill creates section 662.113 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 March 4, 2015:**
The committee substitute clarifies that the OFR may investigate any entity to determine compliance with ch. 662, F.S. The CS provides that family trust companies operating on October 1, 2015, must apply for licensure or registration by December 30, 2015. It allows a family trust company or licensed family trust company to make purchases as a fiduciary directly from broker-dealers. The CS also expands the scope of examinations of licensed family trust companies and provides procedures for reinstatements of licenses or registrations.

[13] *See* Real Property, Probate, and Trust Law Section of the Florida Bar White Paper on Proposed Changes to the Florida Family Trust Company Act (on file with Committee on Banking and Insurance Committee staff).
[14] *See* SB 568 2015 Legislative Bill Analysis Office of Financial Regulation.

B. Amendments:

None.

**By** Senator Richter

23-00212B-15 2015568__

A bill to be entitled

An act relating to family trust companies; amending s. 662.102, F.S.; revising the purposes of the Family Trust Company Act; providing legislative findings; amending s. 662.111, F.S.; redefining the term "officer"; creating s. 662.113, F.S.; specifying the applicability of other chapters of the financial institutions codes to family trust companies; providing that the section does not limit the authority of the Office of Financial Regulation to investigate a family trust company to ensure compliance with the chapter and applicable financial institutions codes; amending s. 662.120, F.S.; revising the ancestry requirements for designated relatives of a licensed family trust company; amending s. 662.1215, F.S.; revising the requirements for investigations of license applicants by the Office of Financial Regulation; amending s. 662.122, F.S.; revising the requirements for registration of a family trust company and a foreign licensed family trust company; amending s. 662.1225, F.S.; requiring a foreign licensed family trust company to be in compliance with the family trust laws and regulations in its jurisdiction; amending s. 662.123, F.S.; revising the types of amendments to organizational documents which must have prior approval by the office; amending s. 662.128, F.S.; extending the deadline for the filing of, and revising the requirements for, specified license and registration







23-00212B-15 2015568__

renewal applications; amending s. 662.132, F.S.; revising the prohibition against the purchase of certain bonds or securities by specified family trust companies; amending s. 662.141, F.S.; deleting the requirement that the office examine a family trust company that is not licensed and a foreign licensed family trust company; providing that the office may rely upon specified documentation that identifies the qualifications of beneficiaries as permissible recipients of family trust company services; deleting a provision that authorizes the office to accept an audit by a certified public accountant in lieu of an examination by the office; authorizing the Financial Services Commission to adopt rules establishing specified requirements for family trust companies; amending s. 662.142, F.S.; deleting a provision that authorizes the office to immediately revoke the license of a licensed family trust company under certain circumstances; revising the circumstances under which the office may enter an order revoking the license of a licensed family trust company; amending s. 662.143, F.S.; revising the acts that may result in the entry of a cease and desist order against specified family trust companies and affiliated parties; amending s. 662.145, F.S.; revising the office's authority to suspend a family trust company-affiliated party who is charged with a specified felony or to restrict or prohibit the participation of such party in certain financial institutions; amending

ss. 662.150 and 662.151, F.S.; making technical changes; providing an effective date.

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

Section 1. Section 662.102, Florida Statutes, is amended to read:

662.102 Purposes; findings ~~Purpose~~.—The purposes ~~purpose~~ of the Family Trust Company Act are ~~is~~ to establish requirements for licensing family trust companies, to regulate ~~provide regulation of those~~ persons who provide fiduciary services to family members of no more than two families and their related interests as a family trust company, and to establish the degree of regulatory oversight required of the Office of Financial Regulation over such companies. The ~~Unlike trust companies formed under chapter 658, there is no~~ public interest ~~to be~~ served by this chapter is to ensure ~~outside of ensuring~~ that fiduciary activities performed by a family trust company are restricted to family members and their related interests and as otherwise provided ~~for~~ in this chapter. Therefore, the Legislature finds that:

(1) A family trust company is ~~companies are~~ not a financial institution ~~institutions~~ within the meaning of the financial institutions codes.~~, and~~ Licensure of such a company ~~these companies~~ pursuant to chapters 658 and 660 is ~~should~~ not ~~be~~ required as it would not promote the purposes of the codes specified ~~as set forth~~ in s. 655.001.

(2) A family trust company may elect to be a licensed family trust company under this chapter if the company desires





to be subject to the regulatory oversight of the office, as provided in this chapter, notwithstanding that the company restricts its services to family members.

(3) With respect to: ~~Consequently, the office~~

(a) A licensed ~~of Financial Regulation is not responsible for regulating~~ family trust company, the office is responsible for regulating, supervising, and examining the company as provided under this chapter.

(b) A family trust company that does not elect to be licensed and a foreign licensed family trust company, ~~companies to ensure their safety and soundness, and the responsibility of~~ the office's role ~~office~~ is limited to ensuring that fiduciary services provided by the company ~~such companies~~ are restricted to family members and authorized related interests and not to the general public. The office is not responsible for examining a family trust company or a foreign licensed family trust company regarding the safety or soundness of its operations.

Section 2. Subsection (19) of section 662.111, Florida Statutes, is amended to read:

662.111 Definitions.—As used in this chapter, the term:

(19) "Officer" of a family trust company means an individual, regardless of whether the individual has an official title or receives a salary or other compensation, who may participate in the major policymaking functions of a family trust company, other than as a director. The term does not include an individual who may have an official title and exercise discretion in the performance of duties and functions, but who does not participate in determining the major policies of the family trust company and whose decisions are limited by

policy standards established by other officers, regardless of whether the policy standards have been adopted by the board of directors. The chair of the board of directors, the president, the chief officer, the chief financial officer, the senior trust officer, and all executive vice presidents of a family trust company, and all managers if organized as a limited liability company, are presumed to be ~~executive~~ officers unless such officer is excluded~~,~~ by resolution of the board of directors or members or by the bylaws or operating agreement of the family trust company, other than in the capacity of a director, from participating in major policymaking functions of the family trust company, and such excluded officer does not actually participate therein.

Section 3. Section 662.113, Florida Statutes, is created to read:

662.113 Applicability of other chapters of the financial institutions codes.—If a family trust company, licensed family trust company, or foreign licensed family trust company limits its activities to the activities authorized under this chapter, the provisions of other chapters of the financial institutions codes do not apply to the trust company unless otherwise expressly provided in this chapter. This section does not limit the office's authority to investigate any such trust company to ensure that it is in compliance with this chapter and applicable financial institutions codes.

Section 4. Subsection (2) of section 662.120, Florida Statutes, is amended to read:

662.120 Maximum number of designated relatives.—

(2) A licensed family trust company may ~~not~~ have up to ~~more~~





~~than~~ two designated relatives.~~, and~~ The designated relatives may not have a common ancestor within three ~~five~~ generations.

Section 5. Paragraph (e) is added to subsection (2) of section 662.1215, Florida Statutes, to read:

662.1215 Investigation of license applicants.—

(2) Upon filing an application for a license to operate as a licensed family trust company, the office shall conduct an investigation to confirm:

(e) That the management structure of the proposed company complies with s. 662.125.

Section 6. Paragraph (b) of subsection (1) and paragraphs (a) and (c) of subsection (2) of section 662.122, Florida Statutes, are amended to read:

662.122 Registration of a family trust company or a foreign licensed family trust company.—

(1) A family trust company that is not applying under s. 662.121 to become a licensed family trust company must register with the office before beginning operations in this state. The registration application must:

(b) State that the family trust company is a family trust company as defined under this chapter and that its operations will comply with ss. 662.1225, 662.123(1), 662.124, 662.125, 662.127, 662.131, and 662.134.

(2) A foreign licensed family trust company must register with the office before beginning operations in this state.

(a) The registration application must state that its operations will comply with ss. 662.1225, 662.125, 662.127, 662.131, and 662.134 and that it is currently in compliance with the family trust company laws and regulations of its principal

jurisdiction.

(c) The registration must include a certified copy of a certificate of good standing, or an equivalent document, authenticated by the official having custody of records in the jurisdiction where the foreign licensed family trust company is organized, along with satisfactory proof, as determined by the office, that the company is organized in a manner similar to a family trust company as defined under this chapter and is in compliance with the family trust company laws and regulations of its principal jurisdiction.

Section 7. Subsection (2) of section 662.1225, Florida Statutes, is amended to read:

662.1225 Requirements for a family trust company, licensed family trust company, and foreign licensed family trust company.—

(2) In order to operate in this state, a foreign licensed family trust company must be in good standing in its principal jurisdiction, must be in compliance with the family trust company laws and regulations of its principal jurisdiction, and must maintain:

(a) An office physically located in this state where original or true copies of all records and accounts of the foreign licensed family trust company pertaining to its operations in this state may be accessed and made readily available for examination by the office in accordance with this chapter.

(b) A registered agent who has an office in this state at the street address of the registered agent.

(c) All applicable state and local business licenses,





charters, and permits.

(d) A deposit account with a state-chartered or national financial institution that has a principal or branch office in this state.

Section 8. Subsection (2) of section 662.123, Florida Statutes, is amended to read:

662.123 Organizational documents; use of term "family trust" in name.—

(2) A proposed amendment to the articles of incorporation, articles of organization, certificate of formation, or certificate of organization~~, bylaws, or articles of organization~~ of a ~~limited liability company,~~ family trust company~~,~~ or licensed family trust company must be submitted to the office for review at least 30 days before it is filed or effective. An amendment is not considered filed or effective if the office issues a notice of disapproval with respect to the proposed amendment.

Section 9. Subsections (1) through (4) of section 662.128, Florida Statutes, are amended to read:

662.128 Annual renewal.—

(1) Within 45 ~~30~~ days after the end of each calendar year, a family trust company ~~companies~~, licensed family trust company ~~companies~~, or ~~and~~ foreign licensed family trust company ~~companies~~ shall file its ~~their~~ annual renewal application with the office.

(2) The license renewal application filed by a licensed family trust company must include a verified statement by an authorized representative of the trust company that:

(a) The licensed family trust company operated in full

compliance with this chapter, chapter 896, or similar state or federal law, or any related rule or regulation. The application must include proof acceptable to the office that the company is a family trust company as defined under this chapter.

(b) Describes any material changes to its operations, principal place of business, directors, officers, managers, members acting in a managerial capacity, and designated relatives since the end of the preceding calendar year.

(3) The registration renewal application filed by a family trust company must include:

(a) A verified statement by an authorized representative ~~officer~~ of the trust company that it is a family trust company as defined under this chapter and that its operations are in compliance with ss. 662.1225, 662.123(1), 662.124, 662.125, 662.127, 662.131, and 662.134, ~~,~~ chapter 896, ~~,~~ or similar state or federal law~~,~~ or ~~any~~ related rule or regulation.

(b) ~~, and include~~ The name of the company's ~~its~~ designated relative or relatives, if applicable, and the street address for its principal place of business.

(4) The registration renewal application filed by a foreign licensed family trust company must include a verified statement by an authorized representative of the trust company that its operations are in compliance with ss. 662.1225, 662.125, 662.131, and 662.134 and in compliance with the family trust company laws and regulations of its principal jurisdiction. It must also provide:

(a) The current telephone number and street address of the physical location of its principal place of business in its principal jurisdiction.





(b) The current telephone number and street address of the physical location in this state of its principal place of operations where its books and records pertaining to its operations in this state are maintained.

(c) The current telephone number and address of the physical location of any other offices located in this state.

(d) The name and current street address in this state of its registered agent.

(e) Documentation satisfactory to the office that the foreign licensed family trust company is in compliance with the family trust company laws and regulations of its principal jurisdiction.

Section 10. Subsection (7) of section 662.132, Florida Statutes, is amended to read:

662.132 Investments.—

(7) Notwithstanding subsections (1)-(6), a family trust company or licensed family trust company may not, while acting as a fiduciary, purchase a bond or security issued by the company or its parent, or a subsidiary company ~~an affiliate~~ thereof or its parent, unless:

(a) The family trust company or licensed family trust company is expressly authorized to do so by:

1. The terms of the instrument creating the trust;

2. A court order;

3. The written consent of the settlor of the trust for which the family trust company or licensed family trust company is serving as trustee; or

4. The written consent of every adult qualified beneficiary of the trust who, at the time of such purchase, is entitled to

receive income under the trust or who would be entitled to receive a distribution of principal if the trust were terminated; and

(b) The purchase of the security is at a fair price and complies with:

1. The prudent investor rule in s. 518.11~~,~~ or other prudent investor or similar rule under other applicable law, unless ~~such~~ compliance is waived in accordance with s. 518.11 or other applicable law.

2. The terms of the instrument, judgment, decree, or order establishing the fiduciary relationship.

Section 11. Section 662.141, Florida Statutes, is amended to read:

662.141 Examination, investigations, and fees.—The office may conduct an examination or investigation of a family trust company, licensed family trust company, or foreign licensed family trust company at any time it deems necessary to determine whether the ~~a~~ family trust company, licensed family trust company, or foreign licensed family trust company, or family trust company-affiliated party thereof ~~person~~ has violated or is about to violate any provision of this chapter, ~~or rules adopted by the commission pursuant to this chapter, or~~ any applicable provision of the financial institution codes, or any rule ~~rules~~ adopted by the commission pursuant to this chapter or the ~~such~~ codes.

(1) The office may rely upon a certificate of trust, trust summary, or written statement from the trust company which identifies the qualified beneficiaries of any trust or estate for which a family trust company, licensed family trust company,







or foreign licensed family trust company serves as a fiduciary and the qualifications of such beneficiaries as permissible recipients of company services.

(2) The office shall conduct an examination of a licensed family trust company~~, family trust company, and foreign licensed family trust company~~ at least once every 36 ~~18~~ months.

~~(2) In lieu of an examination by the office, the office may accept an audit of a family trust company, licensed family trust company, or foreign licensed family trust company by a certified public accountant licensed to practice in this state who is independent of the company, or other person or entity acceptable to the office. If the office accepts an audit pursuant to this subsection, the office shall conduct the next required examination.~~

~~(3)~~ The office shall examine the books and records of a ~~family trust company or~~ licensed family trust company as necessary to determine whether it is a ~~family trust company or~~ licensed family trust company as defined in this chapter~~,~~ and is operating in compliance with this chapter ~~ss. 662.1225, 662.125, 662.126, 662.131, and 662.134, as applicable~~. ~~The office may rely upon a certificate of trust, trust summary, or written statement from the trust company identifying the qualified beneficiaries of any trust or estate for which the family trust company serves as a fiduciary and the qualification of the qualified beneficiaries as permissible recipients of company services. The commission may establish by rule the records to be maintained or requirements necessary to demonstrate conformity with this chapter as a family trust company or licensed family trust company.~~

(3) ~~(4)~~ The office shall examine the books and records of a foreign licensed family trust company as necessary to determine if it is a foreign licensed trust company as defined in this chapter and is in compliance with ss. 662.1225, 662.125, 662.130(2), 662.131, and 662.134. In connection with an examination of the books and records of the company, the office may rely upon the most recent examination report or review or certification letters or similar documentation issued by the regulatory agency to which the foreign licensed family trust company is subject to supervision. ~~The commission may establish by rule the records to be maintained or requirements necessary to demonstrate conformity with this chapter as a foreign licensed family trust company.~~ The office's examination of the books and records of a foreign licensed family trust company is, to the extent practicable, limited to books and records of the operations in this state.

(4) ~~(5)~~ For each examination of the books and records of a family trust company, licensed family trust company, or foreign licensed family trust company as authorized under this chapter, the trust company shall pay a fee for the costs of the examination by the office. As used in this section, the term "costs" means the salary and travel expenses of field staff which are directly attributable to the examination of the trust company and the travel expenses of any supervisory and ~~or~~ support staff required as a result of examination findings. The mailing of payment for costs incurred must be postmarked within 30 days after the receipt of a notice stating that the ~~such~~ costs are due. The office may levy a late payment of up to $100 per day or part thereof that a payment is overdue~~,~~ unless waived







for good cause. However, if the late payment of costs is intentional, the office may levy an administrative fine of up to $1,000 per day for each day the payment is overdue.

(5) ~~(6)~~ All fees collected under this section must be deposited into the Financial Institutions' Regulatory Trust Fund pursuant to s. 655.049 for the purpose of administering this chapter.

(6) The commission may establish by rule the records to be maintained or requirements necessary to demonstrate conformity with this chapter as a family trust company, licensed family trust company, or foreign licensed family trust company.

Section 12. Section 662.142, Florida Statutes, is amended to read:

662.142 Revocation of license.—

(1) Any of the following acts constitute ~~or conduct constitutes~~ grounds for the revocation by the office of the license of a licensed family trust company:

(a) The company is not a family trust company as defined in this chapter.~~;~~

(b) A violation of s. 662.1225, s. 662.123(1)(a), s. 662.125(2), s. 662.126, s. 662.127, s. 662.128, s. 662.130, s. 662.131, s. 662.134, or s. 662.144.~~;~~

(c) A violation of chapter 896, relating to financial transactions offenses, or a ~~any~~ similar state or federal law or ~~any~~ related rule or regulation.~~;~~

(d) A violation of any rule of the commission.~~;~~

(e) A violation of any order of the office.~~;~~

(f) A breach of any written agreement with the office.~~;~~

(g) A prohibited act or practice under s. 662.131.~~;~~

(h) A failure to provide information or documents to the office upon written request.~~;~~ ~~or~~

(i) An act of commission or omission which ~~that~~ is judicially determined by a court of competent jurisdiction to be a breach of trust or ~~of~~ fiduciary duty ~~pursuant to a court of competent jurisdiction~~.

(2) If the office finds ~~Upon a finding~~ that a licensed family trust company has committed any of the acts specified ~~set forth~~ in subsection (1) ~~paragraphs (1)(a)-(h)~~, the office may enter an order suspending the company's license and provide notice of its intention to revoke the license and of the opportunity for a hearing pursuant to ss. 120.569 and 120.57.

(3) If a hearing is not timely requested pursuant to ss. 120.569 and 120.57 or if a hearing is held and it has been determined that the licensed family trust company has committed any of the acts specified in subsection (1) ~~there has been a commission or omission under paragraph (1)(i)~~, the office may ~~immediately~~ enter an order revoking the company's license. A ~~The~~ licensed family trust company has ~~shall have~~ 90 days to wind up its affairs after license revocation. If after 90 days the company is still in operation, the office may seek an order from the circuit court for the annulment or dissolution of the company.

Section 13. Subsection (1) of section 662.143, Florida Statutes, is amended to read:

662.143 Cease and desist authority.—

(1) The office may issue and serve upon a family trust company, licensed family trust company, ~~or~~ foreign licensed family trust company, or ~~upon a~~ family trust company-affiliated





party~~,~~ a complaint stating charges if the office has reason to believe that such company, family trust company-affiliated party, or individual named therein is engaging in or has engaged in any of the following acts ~~conduct that~~:

(a) ~~Indicates that~~ The company is not a family trust company or foreign licensed family trust company as defined in this chapter.~~;~~

(b) ~~Is~~ A violation of s. 662.1225, s. 662.123(1)(a), s. 662.125(2), s. 662.126, s. 662.127, s. 662.128, s. 662.130, or s. 662.134.~~;~~

(c) ~~Is~~ A violation of any rule of the commission.~~;~~

(d) ~~Is~~ A violation of any order of the office.~~;~~

(e) ~~Is~~ A breach of any written agreement with the office.~~;~~

(f) ~~Is~~ A prohibited act or practice pursuant to s. 662.131.~~;~~

(g) ~~Is~~ A willful failure to provide information or documents to the office upon written request.~~;~~

(h) ~~Is~~ An act of commission or omission that is judicially determined by ~~or~~ a court of competent jurisdiction ~~practice that the office has reason~~ to be ~~believe is~~ a breach of trust or ~~of~~ fiduciary duty.~~;~~ ~~or~~

(i) ~~Is~~ A violation of chapter 896 or similar state or federal law or any related rule or regulation.

Section 14. Paragraph (a) of subsection (6) of section 662.145, Florida Statutes, is amended to read:

662.145 Grounds for removal.—

(6) The chief executive officer, or the person holding the equivalent office, of a family trust company or licensed family trust company shall promptly notify the office if he or she has

actual knowledge that a family trust company-affiliated party is charged with a felony in a state or federal court.

(a) If a family trust company-affiliated party is charged with a felony in a state or federal court, or is charged with an offense in a court ~~the courts~~ of a foreign country with which the United States maintains diplomatic relations which involves a violation of law relating to fraud, currency transaction reporting, money laundering, theft, or moral turpitude and the charge is equivalent to a felony charge under state or federal law, the office may enter an emergency order suspending the family trust company-affiliated party or restricting or prohibiting participation by such ~~company-affiliated~~ party in the affairs of that particular family trust company or licensed family trust company or any state financial institution, subsidiary, or service corporation, upon service of the order upon the company and ~~the~~ family trust company-affiliated party ~~so~~ charged.

Section 15. Paragraph (b) of subsection (1) of section 662.150, Florida Statutes, is amended to read:

662.150 Domestication of a foreign family trust company.—

(1) A foreign family trust company lawfully organized and currently in good standing with the state regulatory agency in the jurisdiction where it is organized may become domesticated in this state by:

(b) Filing an application for a license to begin operations as a licensed family trust company in accordance with s. 662.121, which must first be approved by the office, or by filing the prescribed form with the office to register as a family trust company to begin operations in accordance with s.







662.122.

Section 16. Subsection (3) of section 662.151, Florida Statutes, is amended to read:

662.151 Registration of a foreign licensed family trust company to operate in this state.—A foreign licensed family trust company lawfully organized and currently in good standing with the state regulatory agency in the jurisdiction under the law of which it is organized may qualify to begin operations in this state by:

(3) A company in operation as of October 1, 2015, which ~~the effective date of this act that~~ meets the definition of a family trust company must, on or before December 30, 2015, ~~shall have 90 days from the effective date of this act to~~ apply for licensure as a licensed family trust company, register as a family trust company or foreign licensed family trust company, or cease doing business in this state.

Section 17. This act shall take effect October 1, 2015.

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

678

*Meeting Date* | *Bill Number (if applicable)*

Topic Reciprocal

*Amendment Barcode (if applicable)*

Name Sean Stafford

Job Title

Address 115 E. Park

*Street*

Phone

*City* *State* *Zip*

Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against

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

Representing Star d Shield Insurance Group

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)

389942

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: WD | . | |
| 03/04/2015 | . | |
| | . | |
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The Committee on Banking and Insurance (Smith) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 22 - 57
and insert:
Section 2. Section 627.798, Florida Statutes, is amended to read:
627.798 Rulemaking authority.—The commission:
(1) May adopt rules to implement this part.
(2) Shall adopt by rule ~~adopt~~ a form to be used to provide notice to a purchaser-mortgagor that the purchaser-mortgagor is

389942

not protected by the title policy of the mortgagee.

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

And the title is amended as follows:

Delete lines 2 - 9

and insert:

An act relating to insurance; amending s. 624.425, F.S.; providing that the absence of a countersignature does not affect the validity of a policy or contract of insurance; amending s. 627.798, F.S.; authorizing the Financial Services Commission to adopt rules to implement part XIII of ch. 627, F.S.; providing that the act is remedial and

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LEGISLATIVE ACTION

| Senate | . | House |
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| 03/04/2015 | . | |
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The Committee on Banking and Insurance (Smith) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 22 - 57
and insert:
Section 2. Paragraph (a) of subsection (1) of section 626.916, Florida Statutes, is amended to read:
626.916 Eligibility for export.—
(1) No insurance coverage shall be eligible for export unless it meets all of the following conditions:
(a) The full amount of insurance required must not be

180092

procurable, after a diligent effort has been made by the producing agent to do so, from among the insurers authorized to transact and actually writing that kind and class of insurance in this state, and the amount of insurance exported shall be only the excess over the amount so procurable from authorized insurers. Surplus lines agents must verify that a diligent effort has been made by requiring a properly documented statement of diligent effort, which must be in the form prescribed by department rule or, if a form is not prescribed by rule, in the form of an affidavit, from the retail or producing agent. However, to be in compliance with the diligent effort requirement, the surplus lines agent's reliance must be reasonable under the particular circumstances surrounding the export of that particular risk. Reasonableness shall be assessed by taking into account factors which include, but are not limited to, a regularly conducted program of verification of the information provided by the retail or producing agent. Declinations must be documented on a risk-by-risk basis. If it is not possible to obtain the full amount of insurance required by layering the risk, it is permissible to export the full amount.

Section 3. Section 626.931, Florida Statutes, is amended to read:

626.931 ~~Agent affidavit and~~ Insurer reporting requirements.—

~~(1) Each surplus lines agent shall on or before the 45th day following each calendar quarter file with the Florida Surplus Lines Service Office an affidavit, on forms as prescribed and furnished by the Florida Surplus Lines Service~~



~~Office, stating that all surplus lines insurance transacted by him or her during such calendar quarter has been submitted to the Florida Surplus Lines Service Office as required.~~

~~(2) The affidavit of the surplus lines agent shall include efforts made to place coverages with authorized insurers and the results thereof.~~

(1)~~(3)~~ Each foreign insurer accepting premiums shall, on or before the end of the month following each calendar quarter, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during such calendar quarter.

(2)~~(4)~~ Each alien insurer accepting premiums shall, on or before June 30 of each year, file with the Florida Surplus Lines Service Office a verified report of all surplus lines insurance transacted by such insurer for insurance risks located in this state during the preceding calendar year.

(3)~~(5)~~ The department may waive the filing requirements described in subsections (1) and (2) ~~(3) and (4)~~.

(4)~~(6)~~ Each insurer's report and supporting information shall be in a computer-readable format as determined by the Florida Surplus Lines Service Office or shall be submitted on forms prescribed by the Florida Surplus Lines Service Office and shall show for each applicable agent:

(a) A listing of all policies, certificates, cover notes, or other forms of confirmation of insurance coverage or any substitutions thereof or endorsements thereto and the identifying number; and

(b) Any additional information required by the department

or Florida Surplus Lines Service Office.

Section 4. Paragraph (a) of subsection (2) of section 626.932, Florida Statutes, is amended to read:

626.932 Surplus lines tax.—

(2)(a) The surplus lines agent shall make payable to the department the tax related to each calendar quarter's business as reported to the Florida Surplus Lines Service Office, and remit the tax to the Florida Surplus Lines Service Office on or before the 45th day following each calendar quarter ~~at the same time as provided for the filing of the quarterly affidavit, under s. 626.931~~. The Florida Surplus Lines Service Office shall forward to the department the taxes and any interest collected pursuant to paragraph (b), within 10 days of receipt.

Section 5. Paragraph (d) of subsection (1) of section 626.935, Florida Statutes, is amended to read:

626.935 Suspension, revocation, or refusal of surplus lines agent's license.—

(1) The department shall deny an application for, suspend, revoke, or refuse to renew the appointment of a surplus lines agent and all other licenses and appointments held by the licensee under this code, on any of the following grounds:

~~(d) Failure to make and file his or her affidavit or reports when due as required by s. 626.931.~~

Section 6. Subsection (1) of section 626.936, Florida Statutes, is amended to read:

626.936 Failure to file reports or pay tax or service fee; administrative penalty.—

(1) Any licensed surplus lines agent who neglects to file a report ~~or an affidavit~~ in the form and within the time required

180092

or provided for in the Surplus Lines Law may be fined up to $50 per day for each day the neglect continues, beginning the day after the report ~~or affidavit~~ was due until the date the report ~~or affidavit~~ is received. All sums collected under this section shall be deposited into the Insurance Regulatory Trust Fund.

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

And the title is amended as follows:

Delete lines 2 - 9

and insert:

An act relating to insurance; amending s. 624.425, F.S.; providing that the absence of a countersignature does not affect the validity of a policy or contract of insurance; amending s. 626.916, F.S.; requiring the statement of diligent effort from a retail or producing agent be in a specified form; amending s. 626.931, F.S.; deleting provisions that require surplus lines agents to file a quarterly affidavit with the Florida Surplus Lines Office; amending ss. 626.932, 626.935, and 626.936, F.S.; conforming provisions to changes made by act; providing that the act is remedial and

728776

LEGISLATIVE ACTION

| Senate | . | House |
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| Comm: RCS | . | |
| 03/04/2015 | . | |
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The Committee on Banking and Insurance (Smith) recommended the following:

**Senate Amendment (with title amendment)**

Delete lines 58 - 61.

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

And the title is amended as follows:

Delete lines 9 - 11

and insert:

thereto; providing an effective date.

**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 252 |
| INTRODUCER: | Banking and Insurance Committee and Senator Smith |
| SUBJECT: | Insurance Countersignature Requirements |
| DATE: | March 4, 2015 |
| REVISED: | |

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

**Please see Section IX. for Additional Information:**

COMMITTEE SUBSTITUTE - Substantial Changes

## I. Summary:

CS/SB 252 provides that the absence of a countersignature does not affect the validity of a property, casualty, or surety insurance policy or contract. This could reduce the risk that an insured loses coverage due to events the insured cannot control. Current law provides that no property, casualty, or surety insurer shall assume direct liability unless the policy or contract of insurance is countersigned by a licensed agent.

This bill eliminates the requirement that each surplus lines agent must, on or before the 45th day following each calendar quarter, file with the Florida Surplus Lines Service Office (FSLSO) an affidavit stating that all surplus lines insurance he or she transacted during that calendar year has been submitted to the FSLSO and that includes efforts made to place coverage with authorized insurers and the results of those efforts. The requirement is no longer needed because the FSLSO has implemented auditing procedures to confirm the information.

## II. Present Situation:

Section 624.425(1), F.S., requires all property, casualty, and surety insurance policies or contracts to be issued and countersigned by an agent. The agent must be regularly commissioned, currently licensed, and appointed as an agent for the insurer.[1] The purpose of the

[1] An earlier version of s. 624.425, F.S., required a countersignature by licensed agent who was a Florida resident. The residency requirement was held invalid in *Council of Insurance Agents and Brokers v. Gallagher*, 287 F.Supp.2d 1302 (N.D. Fla. 2003).

countersignature requirement is "to protect the public … by requiring such policies to be issued by resident, licensed agents over whom the state can exercise control and thus prevent abuses."[2] The absence of a countersignature does not necessarily invalidate the insurance policy. The insurer may waive the countersignature requirement.[3] If the countersignature requirement is not waived, a policy is not enforceable against the insurer, as a court will not consider the policy properly executed.[4] In the absence of a countersignature, whether a policy is waived is a factual matter determined on a case-by-case basis.[5] In at least one recent case, a defendant argued that the lack of a countersignature constituted a defense in a breach of contract action.[6]

Section 624.426, F.S., excludes some policies from the countersignature requirement. These are:

- Contracts of reinsurance;
- Policies of insurance on the rolling stock of railroad companies doing a general freight and passenger business;
- United States Custom surety bonds issued by a corporate surety approved by the United States Department of Treasury;
- Policies of insurance issued by insurers whose agents represent one company or a group of companies under common ownership if a company within one group is transferring policies to another company within the same group and the agent of record remains the same; and
- Policies of property, casualty, and surety insurance issued by insurers whose agents represent one company or a group of companies under common ownership and for which the application is lawfully submitted to the insurer.[7]

**Surplus Lines Agent Affidavit**

Surplus lines insurance refers to a category of insurance for which there is no market available through standard insurance carriers in the admitted market (insurance companies licensed to transact insurance in Florida). Surplus lines insurance is sold by surplus lines insurance agents.[8] Section 626.916, F.S., requires the insurance agent to make a diligent effort[9] to procure the desired coverage from admitted insurers before the agent can place insurance in the surplus lines market. Surplus lines insurance agents must report surplus lines insurance transactions to the Florida Surplus Lines Service Office (FSLSO or Office) within 30 days of the effective date of the transaction.[10] They must also transmit service fees to the Office each month, and must

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[2] *Wolfe v. Aetna Insurance Company*, 436 So.2d 997, 999 (Fla. 5th DCA 1983)
[3] *See Meltsner v. Aetna Casualty and Surety Company of Hartford, Conn.,* 233 So.2d 849, 850 (Fla. 3rd DCA 1969)(holding under the facts of that case that the countersignature requirement was waived).
[4] 43 AM. JUR. 2d Insurance s. 225.
[5] *See* Meltsner, 233 So. 2d at 850 (finding a waiver of the countersignature requirement); Wolfe, 436 So.2d at 999 (finding a waiver of the countersignature requirement); *CNA Intern. Reinsurance Co. Ltd. v. Phoenix,*678 So.2d 378 (Fla. 1st DCA 1996)(noting that the countersignature requirement may be waived).
[6] *See FCCI Insurance Company v. Gulfwind Companies, LLC,* 2013 CC 003056 NC (Fla. Sarasota County Court).
[7] *See* s. 624.426, F.S.
[8] *See* s. 626.915(3), F.S.
[9] Section 626.914, F.S., defines a diligent effort as seeking and being denied coverage from at least three authorized insurers in the admitted market unless the cost to replace the property insured is $1 million or more. In that case, diligent effort is seeking and being denied coverage from at least one authorized insurer in the admitted market.
[10] *See* s. 626.921, F.S. (requiring reports of transactions as required by the FSLSO Plan of Operation); http://www.fslso.com/publications/manuals/Agents.Procedures.Manual.pdf (requiring reports within 30 days).

transmit assessment and tax payments to the Office quarterly.[11] Current law also requires a surplus lines agent to file a quarterly affidavit with the FSLSO to document all surplus lines insurance transacted in the quarter it was submitted to the FSLSO.[12] The affidavit also documents the efforts the agent made to place coverage with authorized insurers and the results of the efforts.[13] The FSLSO audits agents on a tri-annual basis to verify accuracy of submitted data with original source documents.[14]

## III. Effect of Proposed Changes:

This bill provides that the absence of a countersignature does not affect the validity of a policy or contract of insurance. This bill does not repeal the countersignature requirement; it provides that the failure to obtain a countersignature does not invalidate the policy or contract. This bill also provides that the provision is remedial and intended to clarify existing law.

This bill repeals s. 626.931(1) and s. 626.931(2), F.S., requiring a surplus lines agent to file quarterly reports stating that all surplus lines transactions have been submitted to the FSLSO and requiring that such reports include an affidavit of diligent effort. The FSLSO reports that the provisions are no longer necessary. The FSLSO receives the information relating to the surplus lines transactions from the agents and the insurers and has implemented audit procedures to verify the information. The diligent effort affidavit is required under s. 626.916(1), F.S.

This bill makes conforming changes to ss. 626.932, 626.935, and 626.936, F.S.

This bill takes effect July 1, 2015.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[11] *See* ss. 626.932, 626.9325, F.S.
[12] *See* s. 626.931(1), F.S.
[13] *See* s. 626.932(2), F.S.
[14] E-mail from the FSLSO (on file with committee staff).

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 624.425, 626.916, 626.931, 626.932, 626.935, and 626.935.

## 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 March 4, 2015:**
The committee substitute removes a provision of the bill providing that the bill was retroactive until 1959. It also repeals s. 626.931(1) and s. 626.931(2), F.S., requiring a surplus lines agent to file quarterly reports stating that all surplus lines transactions have been submitted to the FSLSO and requiring that such reports include an affidavit of diligent effort.

B. Amendments:

None.

**By** Senator Smith

31-00417-15 2015252__

A bill to be entitled

An act relating to insurance countersignature requirements; amending s. 624.425, F.S.; providing that the absence of a countersignature does not affect the validity of a policy or contract of insurance; reenacting ss. 626.025(11), 626.752(3)(f), and 628.909(2)(a) and (3)(a), F.S., to incorporate the amendment made to s. 624.425, F.S., in references thereto; providing that the act is remedial and intended to clarify existing law; providing for retroactive application; providing an effective date.

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

Section 1. Subsection (6) is added to section 624.425, Florida Statutes, to read:

624.425 Agent countersignature required, property, casualty, surety insurance.—

(6) The absence of a countersignature required under this section does not affect the validity of a policy or contract of insurance.

Section 2. For the purpose of incorporating the amendment made by this act to section 624.425, Florida Statutes, in a reference thereto, subsection (11) of section 626.025, Florida Statutes, is reenacted to read:

626.025 Consumer protections.—To transact insurance, agents shall comply with consumer protection laws, including the following, as applicable:

(11) Countersignature of insurance policies, as required







31-00417-15 2015252__

under s. 624.425, s. 624.426, or s. 626.741.

Section 3. For the purpose of incorporating the amendment made by this act to section 624.425, Florida Statutes, in a reference thereto, paragraph (f) of subsection (3) of section 626.752, Florida Statutes, is reenacted to read:

626.752 Exchange of business.—

(3)

(f) Policies written in accordance with this section shall be properly countersigned in accordance with the provisions of s. 624.425.

Section 4. For the purpose of incorporating the amendment made by this act to section 624.425, Florida Statutes, in a reference thereto, paragraph (a) of subsection (2) and paragraph (a) of subsection (3) of section 628.909, Florida Statutes, are reenacted to read:

628.909 Applicability of other laws.—

(2) The following provisions of the Florida Insurance Code apply to captive insurance companies who are not industrial insured captive insurance companies to the extent that such provisions are not inconsistent with this part:

(a) Chapter 624, except for ss. 624.407, 624.408, 624.4085, 624.40851, 624.4095, 624.411, 624.425, and 624.426.

(3) The following provisions of the Florida Insurance Code shall apply to industrial insured captive insurance companies to the extent that such provisions are not inconsistent with this part:

(a) Chapter 624, except for ss. 624.407, 624.408, 624.4085, 624.40851, 624.4095, 624.411, 624.425, 624.426, and 624.609(1).

Section 5. The amendment made by this act to s. 624.425,

Florida Statutes, is remedial in nature, is intended to clarify existing law, and applies retroactively to the enactment of s. 624.425, Florida Statutes, on October 1, 1959.

Section 6. This act shall take effect July 1, 2015.



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

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

3/4/15
*Meeting Date*

252
*Bill Number (if applicable)*

Topic _____

*Amendment Barcode (if applicable)*

Name Paul Sanford

Job Title _____

Address 106 S. Monroe St
*Street*

Tallahassee, FL 32301
*City* *State* *Zip*

Phone 850-222-7200

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Speaking: ☐ For ☐ Against ☒ Information

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

Representing FCCI - Florida Insurance Council

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 830 |
| INTRODUCER: | Senator Simmons |
| SUBJECT: | Regulation of Corporation Not for Profit Self-insurance Funds |
| DATE: | March 3, 2015 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Johnson | Knudson | BI | **Pre-meeting** |
| 2. | | | CM | |
| 3. | | | FP | |

## I. Summary:

SB 830 expands the types of entities that are eligible to be members of a corporation not for profit self-insurance fund authorized under s. 624.4625, F.S. In 2007, the Legislature authorized two or more not-for-profit corporations to create a self-insurance fund for purposes of pooling property or casualty insurance, if each member of the fund receives at least 75 percent of its revenue from governmental sources, and other conditions are met.[1] SB 830 maintains this requirement but also allows publicly supported organizations under section 501(c)(3) of the Internal Revenue Code receiving at least 75 percent of its support from a governmental unit or the public, to be a member of the fund. The eligibility of such an entity would be supported on the most recent Internal Revenue Service Form 990 or Form 990EZ and Schedule A.

## II. Present Situation:

### Regulation of Self-Insurance Funds

The Office of Insurance Regulation (OIR) regulates the activities of insurers and other risk-bearing entities.[2] As an alternative to obtaining insurance from a licensed insurance company, the current law allows certain persons to form and obtain insurance coverage from a self-insurance fund. Generally, the members of a self-insurance fund assume the risk of loss among themselves, rather than transferring the risk to an insurance company.[3]

[1] Section 14, chapter 2007-1, Laws of Florida.

[2] Section 20.121(3)(a)1., F.S.

[3] The Commercial Self-Insurance Fund Act (ss. 624.460-624.488, F.S.), authorizes certain groups and associations to form a commercial self-insurance fund, subject to the approval of OIR. Under s. 624.4621, F.S., two or more employers may pool their workers' compensation liabilities and form a self-insurance fund for workers' compensation purposes, referred to as a group self-insurance fund. Such funds must comply with administrative rules adopted by the Financial Services Commission. Pursuant to s. 624.4622, F.S., any two local governments may enter into interlocal agreements to create a self-insurance fund for securing the payment of benefits under the workers' compensation law. Under s. 624.4623, F.S., any two or more independent non-profit colleges or universities may form a self-insurance fund for the purpose of pooling and spreading

Section 624.4625, F.S., provides that two or more not-for-profit corporations[4] located and organized under Florida law may form a self-insurance fund. The purpose of the self-insurance fund must be to pool and spread the property and casualty liabilities of group members. The fund must meet a number of requirements including that it:

- Has annual normal premiums in excess of $5 million;
- Has only members who receive at least 75 percent of its revenues from local, state, or federal governmental sources;
- Uses a qualified actuary to determine actuarially sound rates and adequate reserves and submits annual certifications to the OIR;
- Maintains excess insurance coverage; and
- Submits an annual audited financial report to the OIR.

A corporation not for profit self-insurance fund that meets the requirements of this section is not an insurer for purposes of participation in or coverage by any guaranty association established under ch. 631, F.S. Further, such a self-insurance fund is not subject to s. 624.4621, F.S., and is not required to file any report with the Department of Financial Services under s. 440.38(2)(b), F.S., that is uniquely required of group self-insurer funds qualified under s. 624.4621, F.S.

**Florida Insurance Trust**

The Florida Insurance Trust (FIT) is a corporation not for profit self-insurance fund created in 2007. Currently, FIT has approximately 175 participating non-profit social service entities.[5] According to representatives of FIT, the existing statutes provide for a potential field of membership of 9,000, of which only 175 are currently members. FIT provides property, general liability, professional liability, employment practice liability, workers compensation, health insurance, and commercial automobile coverage to its members.

FIT is required to ensure that all members are eligible pursuant to s. 624.4625, F.S. Any potential member is required to submit a notarized certification, signed by an officer of the member, that at least 75 percent of funding comes from governmental sources as required under s. 624.4625, F.S. Each member must submit Form 990 for review and, if necessary, audited financial statements to confirm compliance with eligibility requirements. [6] Recently, during an OIR inquiry into FIT's process for determining eligibility of members, FIT noted that four entities did not meet statutory eligibility requirements.[7] According to the OIR, FIT represented that these accounts have been nonrenewed. Based on the results of its inquiry, the OIR does not have any objections to the manner in which FIT reviews eligibility. The OIR determined that none of the entities brought to its attention, except for the four entities referenced above, were ineligible for membership.

liabilities of its group members in any property or casualty risk or surety insurance or securing the payment of benefits under the workers' compensation law.

[4] Section 617.1803, F.S., defines the term, "corporation not for profit" to mean a corporation no part of the income or profit of which is distributable to its members, directors, or officers, except as otherwise provided under this chapter.

[5] Florida Insurance Trust, *Florida Insurance Trust Current Membership Overview* (February 27, 2015) (on file with the Senate Committee on Banking and Insurance).

[6] Office of Insurance Regulation letter to the Florida Insurance Trust (July 25, 2014) (on file with the Senate Banking and Insurance Committee).

[7] *Id*.

In the event premiums are inadequate, the trustees of FIT, or an agency or court of competent jurisdiction may assess members of FIT for payment of the obligations of FIT as necessary based proportionately on premiums earned from each member. If one or more members fail to pay the assessment, the other members are liable on a proportionate basis for an additional assessment.

**Section 501(c)(3) Tax Exempt Organizations**

Organizations described in section 501(c)(3) of the Internal Revenue Code are commonly referred to as *charitable organizations*. To qualify as exempt from federal income tax, an organization must meet requirements set forth in the Internal Revenue Code and apply for recognition of an exemption. For section 501(c)(3) organizations, the law provides only limited exceptions to this requirement. Applying for recognition of an exemption results in formal IRS recognition of an organization's status, and may be preferable for that reason. To be tax-exempt under section 501(c)(3) of the Internal Revenue Code, an organization must be organized and operated exclusively for exempt purposes[8] set forth in section 501(c)(3) of the Internal Revenue Code, and none of its earnings may inure to any private shareholder or individual.[9]

Generally, exempt organizations, other than private foundations, that are described in section 501(c)(3) must file their annual information returns on Form 990 or 990-EZ, unless excepted from filing and must also complete Schedule A. Schedule A is used to report and substantiate information about an organization's public charity status and public support.

## III. Effect of Proposed Changes:

SB 830 expands the types of entities that are eligible to be members of a corporation not for profit self-insurance fund authorized under s. 624.4625, F.S. Currently, two or more not-for-profit corporations may create a self-insurance fund for purposes of pooling property or casualty insurance, if each member of the fund receives at least 75 percent of its revenue from governmental sources, and other conditions are met.[10] SB 830 maintains this requirement and allows publicly supported organizations under section 501(c)(3) receiving at least 75 percent of its support from a governmental unit or the public, to be a member of the fund. The eligibility of such an entity would be evidenced on the most recent Internal Revenue Service Form 990 or Form 990EZ and Schedule A.

The bill would take effect July 1, 2015.

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[8] The exempt purposes set forth in section 501(c)(3) are charitable, religious, educational, scientific, literary, testing for public safety, fostering national or international amateur sports competition, and preventing cruelty to children or animals. The term *charitable* is used in its generally accepted legal sense and includes relief of the poor, the distressed, or the underprivileged; advancement of religion; advancement of education or science; erecting or maintaining public buildings, monuments, or works; lessening the burdens of government; lessening neighborhood tensions; eliminating prejudice and discrimination; defending human and civil rights secured by law; and combating community deterioration and juvenile delinquency. *See* http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/Exempt-Purposes-Internal-Revenue-Code-Section-501(c)(3) (last visited February 28, 2015).

[9] *See* Internal Revenue Service, *Frequently Asked Questions about Applying for Tax Exemption* accessible at*:* http://www.irs.gov/Charities-&-Non-Profits/Frequently-Asked-Questions-About-Applying-for-Tax-Exemption (last visited February 28, 2015).

[10] Section 14, chapter 2007-1, Laws of Florida.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Indeterminate. Premiums, contributions, and assessments received by a corporation not for profit self-insurance fund are subject to the premium tax, like insurers, except that the tax rate is 1.6 percent (instead of 1.75 percent) of the gross amount of such premiums, contribution, and assessments.

B. Private Sector Impact:

The bill would allow public support organizations that are 501(c)(3) entities and receive 75 percent of their support from public or governmental sources to become members of a corporation not for profit self-insurance fund organized under s. 624.4625, F.S. By allowing such entities to self-insure as a group, in lieu of obtaining insurance from the private market, such corporations may realize a savings on insurance premiums, assuming the fund has lower expenses than private insurers or more favorable loss experience than insured plans.

According to representatives of the Florida Insurance Trust, SB 830 would allow additional classes of business including Goodwill Industries, Boys & Girls Clubs, food banks, rescue missions (homeless shelters), Salvation Army, Big Brothers Big Sisters, and YMCAs to become members. FIT estimates that the bill would increase the number of additional eligible entities by 125 to 150 entities. FIT asserts that there are a finite number of entities for each of these classes in Florida (9 Goodwill Industries, 41 Boys & Girls Clubs, and 24 YMCAs) that would become members.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends section 624.4625 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 Simmons

10-00263B-15 2015830__

A bill to be entitled

An act relating to the regulation of corporation not for profit self-insurance funds; amending s. 624.4625, F.S.; revising the requirements for a participating member of a corporation not for profit self-insurance fund; providing an effective date.

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

Section 1. Paragraph (b) of subsection (1) of section 624.4625, Florida Statutes, is amended to read:

624.4625 Corporation not for profit self-insurance funds.—

(1) Notwithstanding any other provision of law, any two or more corporations not for profit located in and organized under the laws of this state may form a self-insurance fund for the purpose of pooling and spreading liabilities of its group members in any one or combination of property or casualty risk, provided the corporation not for profit self-insurance fund that is created:

(b) Requires for qualification that each participating member receive at least 75 percent of its revenues from local, state, or federal governmental sources or a combination of such sources or be a publicly supported organization under s. 501(c)(3), which receives at least 75 percent of its support from a governmental unit or the public as evidenced on the organization's most recent Internal Revenue Service Form 990 or Form 990-EZ and Schedule A.

Section 2. This act shall take effect July 1, 2015.



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

# CourtSmart Tag Report

**Room:** EL 110 **Case:** **Type:**
**Caption:** Senate Banking and Insurance Cmte. **Judge:**

**Started: 3/4/2015 1:02:45 PM**
**Ends: 3/4/2015 2:12:40 PM Length: 01:09:56**

| | |
|---|---|
| **1:02:52 PM** | Meeting called to order by Chairman |
| **1:03:05 PM** | Roll call -- quorum present |
| **1:03:31 PM** | Tab 3 - SB 678 - Sen. Diaz e la Portilla |
| **1:04:53 PM** | Roll call on CS/SB 678 -- Favorable |
| **1:05:37 PM** | Tab 2 - SB 522 - Sen. Brandes |
| **1:06:22 PM** | Roll call on SB 522 -- Favorable |
| **1:06:50 PM** | Tab 4 -SB 568 - Senator Richter explains the bill |
| **1:07:32 PM** | Amd. 1 (117136) --adopted |
| **1:08:46 PM** | Amd. 118860 - adoptede |
| **1:08:57 PM** | Amd. 3 (704630) Adopted w/o objection |
| **1:09:26 PM** | Amd. 4 - (437510) -- favorable w/o objection |
| **1:10:38 PM** | Amd. 5 (612190) - adopted |
| **1:11:38 PM** | Amd. 6 (957628) without objection - adopted |
| **1:12:38 PM** | Roll cal on CS/SB 568 - Favorable |
| **1:13:37 PM** | SB 252 - Senator Smith |
| **1:16:14 PM** | CS/SB 252 - Favorable |
| **1:17:25 PM** | SB 830 - Senator Simmons - TP |
| **1:18:33 PM** | President Gaetz - Health Care - Explanation of bill |
| **1:23:51 PM** | Paul Sanford, Florida Blue Florida Insurance Council |
| **1:28:07 PM** | President Gaetz recognized to close on amendment |
| **1:29:26 PM** | Amd. (932076) adopted without objection |
| **1:30:26 PM** | Pam Langford - HEALS of the South |
| **1:32:55 PM** | Charlean M. Lanier, Patient Advocate |
| **1:35:05 PM** | Pam Freeman, MD - FL Society of Rhuematology |
| **1:41:59 PM** | Pam Freeman, MD - FL Society of Rhuematology |
| **1:41:59 PM** | Tammy Perdue, Associated Industries of FL |
| **1:51:11 PM** | Joy Ryan - America's Health Insurance Plan |
| **1:52:25 PM** | Audrey Brown, Florida Association of Health Plans |
| **2:07:01 PM** | President Gaetz recognized to close on bill. |
| **2:11:18 PM** | Roll call on CS/SB 784 - favorable |
| **2:12:22 PM** | meeting adjourned |