Tab 1	**SB 662** by **Stargel (CO-INTRODUCERS) Taddeo**; (Similar to CS/H 00681) Protection for Vulnerable Investors

Tab 2	**SB 784** by **Brandes**; (Compare to CS/CS/H 00465) Insurance

449152	D	S		RCS	BI, Brandes	Delete everything after	02/06 01:09 PM
755264	AA	S		RCS	BI, Brandes	Delete L.52 - 54:	02/06 01:09 PM
~~584058~~	AA	S		WD	BI, Brandes	btw L.1236 - 1237:	02/06 01:09 PM
909708	AA	S	L	RCS	BI, Brandes	btw L.1236 - 1237:	02/06 01:09 PM

Tab 3	**SB 1106** by **Bean**; (Similar to H 00855) Genetic Information Used for Insurance

780580	A	S	L	RCS	BI, Bean	Delete L.53:	02/06 01:09 PM

Tab 4	**SB 1126** by **Brandes**; (Similar to H 01311) Licensure of Check Cashers and Foreign Currency Exchangers

228994	D	S	L	RCS	BI, Brandes	Delete everything after	02/06 01:09 PM

Tab 5	**SB 1304** by **Young**; (Similar to CS/H 01033) Dockless Bicycle Sharing

891624	D	S		RCS	BI, Young	Delete everything after	02/06 01:09 PM
567094	AA	S		RCS	BI, Young	Delete L.81 - 99:	02/06 01:09 PM

Tab 6	**SB 1422** by **Rouson**; (Similar to H 00955) Insurance Coverage Parity for Mental Health and Substance Use Disorders

774792	A	S	L	RCS	BI, Rouson	Delete L.96 - 304:	02/06 01:09 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BANKING AND INSURANCE
Senator Flores, Chair
Senator Steube, Vice Chair

MEETING DATE: Tuesday, February 6, 2018
TIME: 11:00 a.m.—12:30 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Flores, Chair; Senator Steube, Vice Chair; Senators Bracy, Bradley, Braynon, Broxson, Gainer, Garcia, Grimsley, Taddeo, and Thurston

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 662** Stargel (Similar CS/H 681)	Protection for Vulnerable Investors; Authorizing securities dealers, investment advisers, and associated persons to place temporary holds on transactions regarding certain accounts if the dealer, investment adviser, or associated person believes in good faith that exploitation of specified adults has occurred, is occurring, or has been attempted in connection with the transactions and if the dealer, investment adviser, or associated person complies with specified requirements; providing that such holds expire after a specified timeframe, etc. BI 02/06/2018 Favorable CM RC	Favorable Yeas 10 Nays 0
2	**SB 784** Brandes (Compare CS/CS/H 465)	Insurance; Providing an exception from valuation rules for stocks in subsidiaries for certain foreign insurers under certain conditions; exempting foreign insurers from investment requirements relating to subsidiaries and corporations under certain conditions; increasing the amount of capital and surplus required for an insurer to waive a requirement to be an eligible surplus lines insurer; revising circumstances in which insurers may exclude coverage for owners or operators of transportation network company vehicles, etc. BI 02/06/2018 Fav/CS AGG AP	Fav/CS Yeas 10 Nays 0
3	**SB 1106** Bean (Similar H 855)	Genetic Information Used for Insurance; Prohibiting life insurers and long-term care insurers, except under certain circumstances, from canceling, limiting, or denying coverage, or establishing differentials in premium rates, based on genetic information; prohibiting such insurers from certain actions relating to genetic information for any insurance purpose, etc. BI 02/06/2018 Fav/CS HP RC	Fav/CS Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1126** Brandes (Similar H 1311)	Licensure of Check Cashers and Foreign Currency Exchangers; Revising the limit on the aggregate face value of certain payment instruments cashed by a certain person within a specified timeframe before the person is required to be licensed under specified provisions, etc. BI 02/06/2018 Fav/CS RC	Fav/CS Yeas 9 Nays 0
5	**SB 1304** Young (Similar CS/H 1033)	Dockless Bicycle Sharing; Providing insurance requirements for a bicycle sharing company; providing requirements for dockless bicycles made available for reservation by such company, etc. BI 02/06/2018 Fav/CS CA RC	Fav/CS Yeas 8 Nays 2
6	**SB 1422** Rouson (Similar H 955)	Insurance Coverage Parity for Mental Health and Substance Use Disorders; Requiring contracts between the Agency for Health Care Administration and certain managed care plans to require the plans to submit a specified annual report to the agency relating to parity between mental health and substance use disorder benefits and medical and surgical benefits; deleting certain provisions that require insurers, health maintenance organizations, and nonprofit hospital and medical service plan organizations transacting group health insurance or providing prepaid health care to offer specified optional coverage for mental and nervous disorders, etc. BI 02/06/2018 Fav/CS AHS AP	Fav/CS Yeas 10 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 662
INTRODUCER:	Senator Stargel
SUBJECT:	Protection for Vulnerable Investors
DATE:	February 5, 2018
REVISED:	

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

I. Summary:

SB 662 allows a dealer, investment advisor, or an associated person to place a temporary hold on a transaction regarding the account of a specified adult if the dealer, investment advisor, or associated person believes in good faith that exploitation of a specified adult has occurred, is occurring, or has been attempted in connection with the transaction. A specified adult is defined to mean a natural person who is 65 years of age or older or a person 18 years of age or older who is unable to perform the normal activities of daily living or to provide for his or her own care or protection due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

The bill requires the dealer, investment advisor, or associated person to notify all parties authorized to transact business on the account as well as any designated trusted contact, unless such person is believed to be engaged in the suspected exploitation. A delay expires in 15 business days, but the dealer, investment adviser, or associated person may extend the hold for up to 10 additional business days if the facts and circumstances continue to support the good faith belief of suspected exploitation. The length of the hold may be revised at any time by an agency or court of competent jurisdiction.

In response to the increasing financial exploitation of seniors, the Financial Industry Regulatory Authority (FINRA), of which most securities broker-dealers are members, implemented rules to provide its members with the ability to place a hold on a disbursement of funds or securities from a customer's account, if they have a reasonable basis to believe that financial exploitation of a "specified adult" has occurred, is occurring, has been attempted, or will be attempted. The term "specified adult" refers to a natural person age 65 and older; or a natural person age 18 and older who the FINRA member reasonably believes has a mental or physical impairment that renders the individual unable to protect his or her own interests. These rules take effect February 5, 2018. However, they do not apply to broker-dealers and investment advisers who are not FINRA members.

II. Present Situation:

Financial Exploitation of Seniors

With the aging of the U.S. population, financial exploitation of seniors is a serious and growing problem. Senior financial abuse schemes are a $2.9 billion industry.[1] Financial exploitation is a fast-growing form of abuse of seniors and adults with disabilities. Situations of financial exploitation commonly involve trusted persons in the life of the vulnerable adult. Recent research has found that elder financial exploitation is widespread and expensive, as noted:

- One in nine seniors reported being abused, neglected or exploited in the past 12 months; the rate of financial exploitation is extremely high, with 1 in 20 older adults indicating some form of perceived financial mistreatment occurring in the recent past.
- Elder abuse is vastly under-reported; only one in 44 cases of financial abuse is reported.
- Abused seniors are three times more likely to die and elder abuse victims are four times more likely to go into a nursing home.
- 90 percent of abusers are family members or trusted others.
- Almost one in ten financial abuse victims will turn to Medicaid as a direct result of their own monies being stolen from them.
- Cognitive impairment and the need for help with activities of daily living make victims more vulnerable to financial abuse.[2]

Adult Protective Services/Department of Children and Families

The Adult Protective Services Program, under the Department of Children and Families (DCF), is responsible for investigating allegations of abuse, neglect or exploitation, as provided in the Adult Protective Services Act.[3] Section 415.101, F.S., provides that the legislative intent of this act is to provide for the detection and correction of abuse, neglect, and exploitation through social services and criminal investigations and to establish a program of protective services for all vulnerable adults in need of them. Further, it is intended that the mandatory reporting of such cases will cause the protective services of the state to be brought to bear in an effort to prevent further abuse, neglect, and exploitation of vulnerable adults. In taking this action, the Legislature intends to place the fewest possible restrictions on personal liberty and the exercise of constitutional rights, consistent with due process and protection from abuse, neglect, and exploitation.

Handling of Allegations of Abuse, Neglect, or Exploitation

The Florida Abuse Hotline within DCF screens allegations of adult abuse, neglect, and exploitation to determine whether the information meets the criteria. The DCF is required, upon receipt of a report alleging abuse, neglect, or exploitation of a vulnerable adult, to initiate a protective investigation within 24 hours.[4] The APS is responsible for investigating an allegation

[1] National Conference of State Legislatures, *Financial Crimes against the Elderly*, available at http://www.ncsl.org/research/financial-services-and-commerce/financial-crimes-against-the-elderly-2016-legislation.aspx (last viewed Jan. 31, 2018).
[2] National Association of Adult Protective Services Association, *Elder Financial Exploitation*, available at http://www.napsa-now.org/policy-advocacy/exploitation/ (last viewed Jan. 31, 2018).
[3] Sections 415.101-415.113, F.S.
[4] Section 415.104(1), F.S.

involving a vulnerable adult, who is defined to mean a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. For each report it receives, the APS must determine, among other things, if the person meets the definition of a vulnerable adult and, if so, if the person is in need of services, whether there is an indication that the vulnerable adult was abused, neglected, or exploited, and if so, whether protective, treatment, and ameliorative services are necessary to safeguard and ensure the vulnerable adult's wellbeing.[5]

When exploitation has been found to have occurred, APS notifies the appropriate law enforcement agency and the state attorney's office for a possible criminal investigation. The primary function of APS is to safeguard the vulnerable adult[6] and law enforcement is responsible for criminal investigations. The APS may obtain a court order when a vulnerable adult lacks the capacity to consent or to refuse services in order to safeguard the vulnerable adult and their assets. Currently, the APS cannot place a temporary hold on any transaction without a court order.[7]

Mandatory Reporting and Immunity

Section 415.1034, F.S., provides a mandatory requirement for any person to report to the central abuse hotline if they know, have suspicion, or have reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited. Section 415.106, F.S., provides any person reporting or that participates in a judicial proceeding is presumed to be acting in good faith and, unless lack of good faith is shown by clear and convincing evidence, is immune from any civil or criminal liability that otherwise might be incurred or imposed.

Access to Records

Section 415.1045, F.S., provides that the protective investigator, while investigating a report of abuse, neglect, or exploitation, must have access to, inspect, and copy all medical, social, or financial records or documents in the possession of any person, caregiver, guardian, or facility which are relevant to the allegations under investigation, unless specifically prohibited by the vulnerable adult who has capacity to consent. The confidentiality of any medical, social, or financial record or document that is confidential under state law does not constitute grounds for failure to:

- Report as required by s. 415.1034, F.S.;
- Cooperate with the department in its activities under ss. 415.101-415.113, F.S.;
- Give access to such records or documents; or
- Give evidence in any judicial or administrative proceeding relating to abuse, neglect, or exploitation of a vulnerable adult.

The section also provides that if any person refuses to allow a law enforcement officer or the protective investigator to have access to, inspect, or copy any medical, social, or financial record

[5] Section 415.104(2), F.S.
[6] Department of Children and Families; Protecting Vulnerable Adults, *available at* http://www.myflfamilies.com/service-programs/adult-protective-services/protecting-vulnerable-adults (last visited Jan. 31, 2018).
[7] Department of Children and Families, *Analysis of SB 662* (Dec. 6, 2017) (on file with the Senate Banking and Insurance Committee).

or document in the possession of any person, caregiver, guardian, or facility which is relevant to the allegations under investigation, the department may petition the court for an order requiring the person to allow access to the record or document. The petition must allege specific facts sufficient to show that the record or document is relevant to the allegations under investigation and that the person refuses to allow access to such record or document. If the court finds by a preponderance of the evidence that the record or document is relevant to the allegations under investigation, the court may order the person to allow access to and permit the inspection or copying of the medical, social, or financial record or document.

Release of Confidential Information

In order to protect the rights of the individual or other persons responsible for the welfare of a vulnerable adult, all records concerning reports of abuse, neglect, or exploitation of the vulnerable adult, including reports made to the central abuse hotline, and all records generated as a result of such reports are confidential and exempt from s. 119.07(1), F.S., and may not be disclosed except as specifically authorized by ss. 415.101-415.113, F.S.[8] The section provides a few exceptions. Currently, DCF may not share information concerning open cases or disposition of cases with third parties with the exception of law enforcement.[9]

Any person or organization, including DCF, may petition the court for an order making public the records of the DCF, which pertain to investigations of alleged abuse, neglect, or exploitation of a vulnerable adult. The court shall determine whether good cause exists for public access. In making this determination, the court shall balance the best interests of the vulnerable adult who is the focus of the investigation together with the privacy right of other persons identified in the reports against the public interest.[10]

Criminal Penalties

Section 415.111, F.S., provides that a person who knowingly and willfully makes public or discloses any confidential information contained in the central abuse hotline, or in other computer systems, or in the records of any case of abuse, neglect, or exploitation of a vulnerable adult, except as provided in ss. 415.101-415.113, F.S., commits a misdemeanor of the second degree, punishable as provided in s. 775.082, F.S., or s. 775.083, F.S.

Federal Regulation of Securities

Securities Act of 1934

The federal Securities Act of 1934 (‘34 Act), creates the Securities and Exchange Commission, and provides the SEC with broad authority over all aspects of the securities industry. This includes the power to register, regulate, and oversee broker-dealers, brokerage firms, transfer agents, and clearing agencies as well as the nation's securities self-regulatory organizations

[8] Section 415.107, F.S.
[9] Department of Children and Families correspondence (Dec. 20, 2017) (on file with Senate Banking and Insurance Committee).
[10] Section 415.1071, F.S.

(SROs). [11] The New York Stock Exchange, the NASDAQ Stock Market, the Chicago Board of Options, and the Financial Industry Regulatory Authority (FINRA) are forms of SROs.

Generally, any person acting as "broker" or "dealer" as defined in the '34 Act must be registered with the United States Securities and Exchange Commission (SEC) and join a SRO, like the Financial Industry Regulatory Authority (FINRA) or a national securities exchange. The '34 Act broadly defines "broker" as "any person engaged in the business of effecting transactions in securities for the account of others," which the SEC has interpreted to include involvement in any of the key aspects of a securities transaction, including solicitation, negotiation, and execution.[12] A "dealer" is "any person engaged in the business of buying and selling securities…for such person's own account through a broker or otherwise."[13] Certain entities in the securities industry are referred to as "broker-dealers" because the institution is a "broker" when executing trades on behalf of a customer, but is a "dealer" when executing trades for its own account. In addition to being registered with the SEC, broker-dealers must comply with state registration requirements.

FINRA Rules

In April 2015, FINRA launched its Securities Helpline for Seniors, which has highlighted some of the issues firms are facing relating to senior investors, including how firms respond when they suspect a senior customer is being exploited. Two years later, the helpline had fielded more than 8,600 calls and recovered over $4.3 million in voluntary reimbursements from firms to customers. In response to this issue, FINRA proposed rules addressing financial exploitation of specified adults.

In February 2017, the SEC approved the adoption of a new FINRA Rule 2165[14] (Financial Exploitation of Specified Adults) to allow members to place temporary holds on disbursements of funds or securities from the accounts of specified customers where there is a reasonable belief of financial exploitation of these customers. The SEC also adopted amendments to FINRA Rule 4512 (Customer Account Information) to require members to make reasonable efforts to obtain the name of and contact information for a trusted contact person (trusted contact) for a customer's account.[15] Rule 2165 and the amendments to Rule 4512 become effective February 5, 2018. Most broker-dealers in the United States are members of FINRA, therefore, they are subject to FINRA rules and examinations.

Key Provisions of the Rules.[16] The rules provide protections for a specified adult, who is defined as a natural person age 65 or older or a natural person age 18 and older who the member

[11] 15 U.S.C. ss. 78c(4) and 78o; U.S. SECURITIES AND EXCHANGE COMMISSION, *Guide to Broker-Dealer Registration*, http://www.sec.gov/divisions/marketreg/bdguide.htm#II (last visited Jan. 27, 2018).
[12] *Id.*
[13] 15 U.S.C. s. 78c(5).
[14] FINRA, http://finra.complinet.com/en/display/display_main.html?rbid=2403&element_id=12784 (last viewed Jan. 30, 2018).
[15] *See* Securities Exchange Act Release No. 79964 (Feb. 3, 2017), 82 FR 10059 (Feb. 9, 2017) (Notice of Filing of Partial Amendment No. 1 and Order Granting Accelerated Approval of File No. SR-FINRA-2016-039).
[16] FINRA, Frequently Asked Questions Regarding FINRA Rules Relating to Financial Exploitation of Seniors, available at http://www.finra.org/industry/frequently-asked-questions-regarding-finra-rules-relating-financial-exploitation-seniors (last viewed Feb. 3, 2018).

reasonably believes has a mental or physical impairment that renders the individual unable to protect his or her own interests. Rule 2165 provides a safe harbor for a member to place a temporary hold on a disbursement of funds or securities from the account of a specified adult if the member reasonably believes that financial exploitation of the specified adult has occurred, is occurring, has been attempted or will be attempted. Rule 2165 does not apply to transactions in securities. For example, Rule 2165 would not apply to a customer's order to sell his shares of a stock. However, if a customer requested that the proceeds of a sale of shares of a stock be disbursed out of his account at the member, then Rule 2165 could apply to the disbursement of the proceeds where the customer is a specified adult and there is reasonable belief of financial exploitation.

FINRA has stated that, where a questionable disbursement involves less than all assets in an account, a member should not place a blanket hold on the entire account. Each disbursement should be analyzed separately. In addition, FINRA noted that where a disbursement at issue involves all of the assets of the account (*e.g.*, a transfer request), the member must permit disbursements from the account where there is not a reasonable belief of financial exploitation regarding such disbursements (*e.g.*, regular bill payments). FINRA notes that some members intend, for operational reasons, to place a temporary hold or restrictions on an entire account when they have a reasonable belief of financial exploitation regarding a disbursement or disbursements from the account, but also intend to permit legitimate disbursements from the account in these circumstances. FINRA believes that placing a temporary hold or restrictions on an entire account but allowing legitimate disbursements from the account is consistent with Rule 2165 and members may proceed in such a manner as long as they have procedures reasonably designed to permit legitimate disbursements. FINRA emphasizes that a member may not avail itself of the Rule 2165 safe harbor if it blocks disbursements where there is not a reasonable belief of financial exploitation regarding such disbursements.

Florida Regulation of Securities

In addition to federal securities laws, "Blue Sky Laws" are state laws that protect the investing public through registration requirements for both broker dealers and securities offerings, merit review of offerings, and various investor remedies for fraudulent sales practices and activities.[17]

In Florida, the Securities and Investor Protection Act, ch. 517, F.S. (act), regulates securities issued, offered, and sold in the state of Florida. The Florida Office of Financial Regulation (OFR) regulates and registers the offer and sale of securities in, to, or from Florida by firms, branch offices, and individuals affiliated with these firms in accordance with the act. There are 2,607 dealers, 5,984 investment advisers, 10,539 branches, and 319,941 stockbrokers registered in Florida.[18] The act requires the following individuals or businesses to be registered with the OFR under s. 517.12, F.S., in order for such persons to sell or offer to sell any securities in or from offices in this state, or to sell securities to persons in this state from offices outside this state:[19]

[17] U.S. Securities and Exchange Commission, *Blue Sky Laws*, http://www.sec.gov/answers/bluesky.htm (last visited March 30, 2015).
[18]Office of Financial Regulation, *Fast Facts*, available at https://www.flofr.com/StaticPages/documents/FastFacts.pdf (Dec. 2017) (last viewed Feb. 3, 2018).
[19] Section 517.12(1), F.S.

- "Dealers," which include:[20]
  - Any person, other than an associated person registered under ch. 517, F.S., who engages, either for all or part of her or his time, directly or indirectly, as broker or principal in the business of offering, buying, selling, or otherwise dealing or trading in securities issued by another person.
  - Any issuer who through persons directly compensated or controlled by the issuer engages, either for all or part of her or his time, directly or indirectly, in the business of offering or selling securities, which are issued or are proposed to be issued by the issuer.
- "Investment advisers," which:[21]
  - Include any person who receives compensation, directly or indirectly, and engages for all or part of her or his time, directly or indirectly, or through publications or writings, in the business of advising others as to the value of securities or as to the advisability of investments in, purchasing of, or selling of securities, except a dealer whose performance of these services is solely incidental to the conduct of her or his business as a dealer and who receives no special compensation for such services.
  - Does not include a "federal covered adviser."[22]
- "Associated persons," which include:[23]
  - With respect to a dealer or investment adviser, any of the following:
    - Any partner, officer, director, or branch manager of a dealer or investment adviser or any person occupying a similar status or performing similar functions;
    - Any natural person directly or indirectly controlling or controlled by such dealer or investment adviser, other than an employee whose function is only clerical or ministerial; or
    - Any natural person, other than a dealer, employed, appointed, or authorized by a dealer, investment adviser, or issuer to sell securities in any manner or act as an investment adviser as defined in s. 517.021, F.S.
  - With respect to a federal covered adviser, any person who is an investment adviser representative and who has a place of business in this state.

III. Effect of Proposed Changes:

Section 1 creates s. 517.34, F.S., relating to the protection of specified adults.

Definitions

The section specifies the definition for the term "exploitation" has the same meaning as provided in s. 415.102, F.S. The section creates a definition for the term "law enforcement agency" as used in this section. The section specifies the definition for the term "records" has the same meaning as provided in s. 415.102, F.S.

[20] Section 517.021(6)(a), F.S. The term "dealer", as defined under Florida law, encompasses the definitions of "broker" and "dealer" under federal law.
[21] Section 517.021(14)(a), F.S.
[22] Section 517.021(9) and (14)(b)9., F.S. A federal covered adviser must be registered under federal law and must provide a notice filing to the OFR. ss. 517.021 and 517.1201, F.S.
[23] Section 517.021(2), F.S.

The section defines the term, "specified adult," to mean a natural person who is 65 years of age or older or a vulnerable adult as defined in s. 415.102, F.S. Section 415.102, F.S., defines a vulnerable to mean a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

Temporary Holds on Transactions

A dealer, investment adviser, or an associated person may place a temporary hold on a transaction in an account of a specified adult or beneficial owner if the dealer, investment adviser, or associated person believes in good faith that the specified adult is being or has been financially exploited. The dealer, investment adviser or associated person (reporting party) is required to notify DCF of the suspected exploitation in accordance with existing ch. 415, F.S.

Within 3 days of placing a temporary hold on the transaction, the dealer, investment adviser, or associated person must orally or in writing attempt to notify all parties authorized to transact business on the account unless the dealer, investment adviser or associated person believes that any of the parties are involved in the suspected exploitation. A temporary hold expires 15 business days after the date of the temporary hold. However, the dealer, investment adviser or associated person may extend the temporary hold up to an additional 10 business days if a review of the available facts and circumstances continue to support its good faith belief that exploitation of the specified adult has occurred. The length of the hold may be revised by an order of a court of competent jurisdiction or by a written directive from an agency of competent jurisdiction.

Access to Records and Confidential Information

A dealer, investment adviser, or associated person has the discretion to provide access to or copies of any records that are relevant to the suspected exploitation to DCF. Notwithstanding any law to the contrary, the DCF may inform the reporting party on the status of its investigation or any final disposition.

Immunity

Notwithstanding any law to the contrary, the bill grants immunity to a dealer, investment adviser, or associated person from any civil, criminal, or administrative liability for actions taken in accordance with this section. The section does not create new rights or obligations of a dealer, investment adviser or associated person under other applicable laws or rules. The section does not limit the right of a dealer, investment adviser, or associated person to refuse or place a hold on a transaction under other laws or rules or under a customer agreement.

Section 2 provides the bill will take effect July 1, 2018.

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:

Indeterminate. However, the bill will provide additional tools for dealers, investment advisors, and associated persons to protect their senior and other specified adult clients from alleged financial exploitation in a more effective and expedient manner.

C. Government Sector Impact:

Department of Children and Families. Although s. 415.1034, F.S., currently mandates reporting by any person of suspected exploitation of a vulnerable person, the bill may increase awareness and reporting by the securities industry to the Hotline and Adult Protective Services. Implementation of the bill would result in the jurisdiction of the Hotline and APS expanding to include the handling of calls and investigations of persons age 65 and older who are not vulnerable adults as defined in s. 415.102, F.S., as victims of alleged financial exploitation. The additional annual costs to the Hotline is estimated to be $1,888,758.43 to fund 27 Hotline intake FTEs and two supervisors to handle the increased workload. The additional annual cost to APS is estimated to be $10,584,798 to fund an additional 145 investigative positions and 29 supervisor positions to handle the increased workload.[24]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Lines 91-97 of the bill provide "Notwithstanding any law to the contrary, a dealer, an investment adviser, or an associated person is immune from any civil, criminal, or administrative liability for actions taken in accordance with this section. This section may not be construed to form a basis for any civil, criminal, or administrative liability against a dealer, an investment adviser, or an associated person." According to the OFR, this would prevent the OFR from taking

[24] Department of Children and Families, *Analysis of SB 662* (Dec. 6, 2017) (on file with the Senate Committee on Banking and Insurance).

administrative action against persons violating the requirements in any way, such as acting in bad faith. It would also prohibit criminal penalties or civil action for their doing so.[25]

VIII. Statutes Affected:

This bill creates section 517.34 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[25] Office of Financial Regulation, *Analysis of SB 662* (Nov. 14, 2017) (on file with Senate Committee on Banking and Insurance).

By Senator Stargel

22-00777B-18 2018662__

A bill to be entitled

An act relating to protection for vulnerable investors; creating s. 517.34, F.S.; defining terms; authorizing securities dealers, investment advisers, and associated persons to place temporary holds on transactions regarding certain accounts if the dealer, investment adviser, or associated person believes in good faith that exploitation of specified adults has occurred, is occurring, or has been attempted in connection with the transactions and if the dealer, investment adviser, or associated person complies with specified requirements; providing that such holds expire after a specified timeframe; authorizing dealers, investment advisers, and associated persons to extend holds under certain circumstances for up to a specified timeframe; providing that the length of holds may be shortened or extended by certain courts or agencies; authorizing dealers, investment advisers, and associated persons to provide certain records to the Department of Children and Families or law enforcement agencies upon request; authorizing the department to inform reporting parties of certain information; providing that dealers, investment advisers, and associated persons are immune from liability for certain actions; providing construction; providing an effective date.

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

22-00777B-18 2018662__

Section 1. Section 517.34, Florida Statutes, is created to read:

517.34 Protection of specified adults.—

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

(a) "Exploitation" has the same meaning as provided in s. 415.102.

(b) "Law enforcement agency" means an agency of this state or a political subdivision of this state or of the United States whose primary responsibility is the prevention and detection of crime or the enforcement of the penal laws of this state or the United States, and whose agents and officers are empowered by law to conduct criminal investigations or to make arrests.

(c) "Records" has the same meaning as provided in s. 415.102.

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

(2) A dealer, an investment adviser, or an associated person may place a temporary hold on a transaction regarding the account of a specified adult or an account for which a specified adult is a beneficiary or beneficial owner if the dealer, investment adviser, or associated person believes in good faith that exploitation of the specified adult has occurred, is occurring, or has been attempted in connection with the transaction, as follows:

(a) Consistent with the requirements of chapter 415, the dealer, investment adviser, or associated person must immediately notify the Department of Children and Families, via its central abuse hotline, of the suspected exploitation.

(b) Within 3 business days after placing a temporary hold on a transaction, the dealer, investment adviser, or associated person must orally or in writing attempt to notify all parties authorized to transact business on the account using the contact information provided for the account, unless the dealer, investment adviser, or associated person believes in good faith that any such party engaged or is engaging in the suspected exploitation of the specified adult.

(3) A temporary hold under subsection (2) expires 15 business days after the date on which the hold was placed. However, the dealer, investment adviser, or associated person may extend the hold for up to 10 additional business days if its review of the available facts and circumstances continues to support its good faith belief that exploitation of the specified adult has occurred, is occurring, or has been attempted. The length of the hold may be shortened or extended at any time by an order of a court of competent jurisdiction or by a written directive from an agency of competent jurisdiction that directs such reduction or extension, including, but not limited to, the Department of Children and Families pursuant to its authority under chapter 415.

(4) A dealer, an investment adviser, or an associated person may provide access to or copies of any records that are relevant to the suspected exploitation of a specified adult to the Department of Children and Families or a law enforcement agency at their request. These records may include records of prior transactions in addition to the transactions comprising the suspected exploitation.

(5) Notwithstanding any law to the contrary, the Department

of Children and Families may inform the reporting party on the status of an investigation initiated under this section and any final disposition.

(6) Notwithstanding any law to the contrary, a dealer, an investment adviser, or an associated person is immune from any civil, criminal, or administrative liability for actions taken in accordance with this section. This section may not be construed to form a basis for any civil, criminal, or administrative liability against a dealer, an investment adviser, or an associated person.

(7) This section may not be construed to create new rights or obligations of a dealer, an investment adviser, or an associated person under other applicable laws or rules. In addition, this section does not limit the right of a dealer, an investment adviser, or an associated person to otherwise refuse or place a hold on a transaction under other applicable laws or rules or under an applicable customer agreement.

Section 2. This act shall take effect July 1, 2018.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on Finance and Tax, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Children, Families, and Elder Affairs
Communications, Energy, and Public Utilities
Governmental Oversight and Accountability
Military and Veterans Affairs, Space, and Domestic Security

SENATOR KELLI STARGEL
Deputy Majority Leader
22nd District

November 13, 2017

The Honorable Anitere Flores
Senate Committee on Banking and Insurance, Chair
320 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399

Dear Chair Flores:

I respectfully request that SB 662, related to *Protection for Vulnerable Investors*, be placed on the Committee on the Banking and Insurance meeting agenda at your earliest convenience.

Thank you for your consideration and please do not hesitate to contact me should you have any questions.

Sincerely,

Kelli Stargel
State Senator, District 22

Cc: James Knudson/ Staff Director
Sheri Green/ AA

REPLY TO:
❒ 2033 East Edgewood Drive, Suite 1, Lakeland, Florida 33803 (863) 668-3028
❒ 322 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5022

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

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

662

Meeting Date | *Bill Number (if applicable)*

Topic Vulnerable Investor Abuse

Amendment Barcode (if applicable)

Name Sean Stafford

Job Title

Address 115 E. Park Ave (*Street*) Phone 727-5000

(*City*) (*State*) (*Zip*) Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against

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

Representing Florida Securities Dealers Assn / Financial Services Institute

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Feb 6th
Meeting Date

662
Bill Number (if applicable)

Topic SB 662 - in Favor

Amendment Barcode (if applicable)

Name Tim Meenan

Job Title

Address 325 W Duval St.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 425-4000

Email Tim@meenanlaw.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing NAIFA Florida

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/2018
Meeting Date

662
Bill Number (if applicable)

Topic Protecting Vulnerable Adults

Amendment Barcode (if applicable)

Name Eddie Thompson

Job Title Dir of State Affairs

Address _____ Phone 321-720-7095
Street

Email EdThompson@Alz.org

City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Alzheimer's Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

462
Bill Number (if applicable)

Topic Vulnerable Adults Bill

Amendment Barcode (if applicable)

Name Anthony DiMarco

Job Title EVP of Govt. Affairs

Address 1001 Thomasville Rd
Street

Tallahassee FL 32303
City *State* *Zip*

Phone 224-2265

Email adimarco@floridabankers.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Bankers Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

662
Bill Number (if applicable)

Topic Speaking on SB 662

Amendment Barcode (if applicable)

Name Courtney Larkin

Job Title Government Relations

Address 200 E Gaines Street
Street

Phone 850.410.9601

Tallahassee FL 32399
City *State* *Zip*

Email Courtney.larkin@flofr.com

Speaking: ☐ For ☐ Against ☒ Information

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

Representing FL Office of Financial Regulation

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

02/06/2018
Meeting Date

662
Bill Number (if applicable)

Topic Vulnerable Investors

Amendment Barcode (if applicable)

Name Warren Husband

Job Title

Address PO Box 10909
Street

Phone (850) 205-9000

Tallahassee FL 32302
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Securities Industry and Financial Markets Assoc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

February 6, 2018
Meeting Date

662
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name Shannon Miller

Job Title _____

Address 6224 NW 43rd Street, Suite B
Street

Phone 352-379-1900

Gainesville FL 32653
City *State* *Zip*

Email shannon@millerelderlawfirm.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Academy of Florida Elder Law Attorneys and Elder Law Section of the Florida Bar

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 784
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Insurance
DATE:	February 8, 2018
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 784 amends numerous provisions of the Florida Insurance Code. This bill:

- Provides that the stock of a subsidiary corporation or related entity of a foreign insurer is exempt from certain limitations on valuation and investment requirements for solvency evaluation purposes in certain circumstances, including permissibility in the insurer's domicile state;
- Provides that an applicant for licensure as an all-lines adjuster certified as a Claims Adjuster Certified Professional from WebCE, Inc., does not have to take the adjuster examination;
- Repeals a requirement that surplus lines insurers request eligibility from the Florida Surplus Lines Service Office;
- Provides a uniform surplus lines tax of 4.936 percent;
- Lowers from $1 million to $700,000 the threshold for exporting a homeowner's property insurance risk to a surplus lines insurer following a single coverage rejection;
- Incorporates a recent amendment of the Gramm-Leach-Bliley Act for purposes of privacy standards applicable to certain notices required by rules adopted by the Department of Financial Services (DFS) and the Financial Services Commission;
- Provides that an insurer may issue an insurance policy without certain signatures;
- Requires that a notice of policy change summarize the changes made to the policy before renewal;
- Provides that an insurer is not required to participate in a mediation of a property insurance claim requested by an assignee of policy benefits;

- Allows motor vehicle insurers to use the Intelligent Mail barcode, or similar method approved by the United States Postal Service, to document proof of mailing of certain required notices;
- Expands the confidentiality of documents submitted to the OIR under Own-Risk and Solvency Assessment requirements to make them inadmissible as evidence in any private civil action, regardless of from whom they were obtained;
- Revises unearned premium reserve requirements for reciprocal insurers; and
- Allows for electronic posting of certain policy information by health maintenance organizations and motor vehicle service agreement companies.

II. Present Situation:

This bill addresses a number of issues related to insurance.

Foreign Insurers (Sections 1 and 2)

Chapter 625, F.S., regulates the financial affairs of insurers admitted in Florida. Sections 625.151 and 625.325, F.S., deal with the valuation of securities other than bonds and limit an insurer's ability to invest in its subsidiaries and related corporations. If the insurer's surplus including investments in subsidiaries does not exceed $100 million, the maximum percentage of investments in the insurer's subsidiaries may not exceed the lesser of:

- Ten percent of the insurer's admitted assets; or
- Fifty percent of the insurer's surplus in excess of the minimum required surplus.[1]

If the surplus of an insurer, including investments in subsidiaries, is $100 million or more, investments in subsidiaries and related corporations may not exceed 25 percent of the insurer's admitted assets.[2]

Section 625.340, F.S., provides that the investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile if of a quality substantially as high as that required for similar funds of like domestic insurers.

Insurance Adjuster Licensure Examination (Section 3)

An adjuster is an individual employed by an insurer to evaluate losses and settle policyholder claims.[3] An adjuster may be licensed as either an "all-lines adjuster" or a "public adjuster."[4] An all-lines adjuster "is a person who, for money, commission, or any other thing of value, directly or indirectly undertakes on behalf of a public adjuster or an insurer to ascertain and determine the amount of any claim, loss, or damage payable under an insurance contract or undertakes to effect settlement of such claim, loss, or damage."[5] Subject to certain exceptions, a public adjuster is someone that is paid by an insured to prepare and file a claim against their insurer.[6]

[1] Sections 625.151(3)(a) and 625.325(2), F.S.
[2] Section 626.151(3)(b), F.S.
[3] https://www.iii.org/resource-center/iii-glossary/A (last visited Jan. 20, 2018).
[4] Section 626.864, F.S.
[5] Sections 626.015(2) and 626.8548, F.S.
[6] Section 626.854, F.S.

Among other requirements, an applicant must pass an examination to obtain an adjuster's license; however, the examination requirement is waived if the applicant has attained certain professional designations that document their successful completion of professional education coursework. An examination is not required for all-lines adjuster applicants with the following professional designations:

- Accredited Claims Adjuster (ACA) from a regionally accredited postsecondary institution in this state;
- Associate in Claims (AIC) from the Insurance Institute of America;
- Professional Claims Adjuster (PCA) from the Professional Career Institute;
- Professional Property Insurance Adjuster (PPIA) from the HurriClaim Training Academy;
- Certified Adjuster (CA) from ALL LINES Training;
- Certified Claims Adjuster (CCA) from AE21 Incorporated; or
- Universal Claims Certification (UCC) from Claims and Litigation Management Alliance (CLM).

DFS must approve the curriculum, which must include comprehensive analysis of basic property and casualty lines of insurance and testing at least equal to that of standard department testing for the all-lines adjuster license.[7] The curriculum must include 40 hours of instruction covering all of the topics in the all-lines adjuster Examination Content Outline adopted by DFS.[8] DFS only approves curriculum related to adjuster licensing for designations listed in s. 626.221(2)(j), F.S.

WebCE, Inc., is a national provider of professional and continuing educational courses.[9] They provide education related to multiple professions, including: insurance, financial planning, accounting, and tax. Participants can obtain the following professional designations from WebCE: Certified Financial Planner (CFP), Certified Investment Management Analyst (CIMA), Certified Private Wealth Advisor (CPWA), and Certified Fraud Examiner (CFE). WebCE provides continuing education to insurance professionals with courses in subjects of life and health, property and casualty, adjuster, and limited lines.

Surplus Lines Insurance (Sections 4, 5, and 6)

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. Before a surplus lines insurance agent can place insurance in the surplus lines market, s. 626.916, F.S., requires the insurance agent to make a diligent effort to procure the desired coverage from admitted insurers. 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.

[7] Section 626.221(2)(j), F.S.
[8] Rule 69B-227.320, F.A.C.
[9] https://www.webce.com/ (last visited Jan. 20, 2018).

Surplus Lines Insurer Registration

The Florida Surplus Lines Service Office (FSLSO) [10] must file a written request with OIR in order for a surplus lines insurer to become eligible to underwrite insurance risks in Florida. Subsequent to the adoption of this requirement, Congress passed the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA).[11] The NRRA requires the eligibility of surplus lines insurers to be determined in compliance with its criteria, unless the state has adopted nationwide uniform eligibility requirements.[12] The OIR has implemented such eligibility determination standards that may be accessed directly by interested surplus lines insurers. Accordingly, surplus lines insurers apply directly to OIR rather than having FSLSO make the written request. The statute requiring such a written request by FSLSO has become superfluous because it conflicts with NRRA and is no longer implemented.

Surplus Lines Premium Tax

Surplus lines policies are taxed at 5 percent of all gross premiums.[13] However, a surplus lines policy written in Florida may cover risks that are only partially located in this state. This is because the insured's business, property, or other risks cross state lines. Since not all states use gross premiums as the taxable base nor use the same tax rate, this can lead to disparities in cost associated with the applicable premium tax law of other states. Florida law provides that, if Florida is the "home" state, as defined the federal Nonadmitted and Reinsurance Reform Act of 2010, the tax is computed on the gross premium to facilitate uniform application of the tax rate to the gross premiums paid on multi-state risks.[14] The law also provides that the surplus lines premium tax is limited to the tax rate in the state where the risk is located. This can result in an effective tax rate on total taxable premiums that is lower than the statutory 5 percent.

Privacy Disclosures (Section 7)

DFS and the Financial Services Commission (Commission) are required to adopt rules governing the use of a consumer's non-public personal financial and health information by regulated entities. The rules must be consistent with and not more restrictive than the requirements of Title V of the Gramm-Leach-Bliley Act of 1999. However, in December 2015, the Gramm-Leach-Bliley Act was amended by the Fixing America's Surface Transportation (FAST) Act, Public Law No. 114-94.

Execution of Policies (Section 8)

Section 627.416, F.S., provides that every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney in fact, employee, or representative duly authorized by the insurer. Insurer representatives have suggested it would be more efficient to allow policies to be issued without a signature as long as consumer protections remain in place.

[10] Section 626.921, F.S.
[11] 15 U.S.C. ss. 8201 *et seq.*
[12] 15 U.S.C. ss. 8204.
[13] Section 626.932(1), F.S.
[14] Section 626.932(3), F.S.

Notice of Change in Policy Terms (Section 9)

Section 627.43141, F.S., provides that an insurer may not change policy terms at renewal unless the insurer issues a notice of change in policy terms. A change in policy terms includes, the modification, addition, or deletion of any term, coverage, duty, or condition from the previous policy, not including typographical or scrivener's errors or the application of mandated legislative changes.[15] The notice may not be used to add optional coverages that increase premium, unless the policyholder affirmatively accepts the optional coverage.[16]

The policyholder must receive advance written notice of the change. If the insurer fails to issue the notice, coverage continues until the next renewal occurs (with proper service of notice) or replacement coverage is obtained. The notice is required to be titled a "Notice of Change in Policy Terms." However, there is no explicit requirement for any other specific content of the notice. It is arguable that a bare notice with the title "Notice of Change in Policy Terms" and containing no meaningful explanation of the change in policy terms complies with the law.

Mediation through the DFS (Section 10)

Section 627.7015, F.S., provides a mediation program for claims under personal lines and commercial residential property insurance policies. Mediation may be requested only by the policyholder, as a first-party claimant, or the insurer. The insurer must pay the costs of the mediation. Mediation is nonbinding. If a settlement agreement is reached and is not rescinded, it shall be binding and act as a release of all specific claims that were presented in that mediation conference.

Issues have arisen over whether an assignee of policy benefits, such as vendor or contractor, is allowed to request mediation through the DFS program.

Proof of Mailing (Section 11)

Current law provides that motor vehicle insurers are required to mail a notice of cancellation or non-renewal to the first named insured on the policy and the applicable insurance agent at least 45 days prior to the effective date of the cancellation or non-renewal. In the case of non-payment of premium, only a 10-day notice is required. For each of these required notices the insurer must use United States postal proof of mailing, certified mail, or registered mail.[17] Current law does not provide for use of the United States Postal Service tracking system known as "intelligent mail barcode."[18]

[15] Section 627.43141(1)(a), F.S.
[16] Section 627.43141(3), F.S.
[17] Section 627.728, F.S.
[18] A mail tracking service offered by the USPS. Information can be found here: https://postalpro.usps.com/node/217 (last visited January 31, 2018).

Bonds for Construction Contracts (Sections 12 and 13)

Under Florida law, there are generally two ways a contractor, subcontractor, materialman, or laborer may help secure or guarantee payment for work performed on a construction project. The first is by filing a lien against the owner's property.

The second way of helping to secure or guarantee payment for work on a construction project is by filing a claim against a payment bond. A "payment bond" is "[a] bond given by a surety to cover any amounts that, because of the general contractor's default, are not paid to a subcontractor or materials supplier."[19] In Florida, a surety issuing a contract bond, such as a payment bond, is treated as an insurer and regulated by the Insurance Code.[20]

Surety insurers[21] that issue construction bonds are governed by the Insurance Code.[22] Under the Code, owners, subcontractors, laborers, or materialmen are deemed insureds or beneficiaries of a construction bond.[23] If an insured or beneficiary must bring a lawsuit against a surety insurer to force payment under the construction bond and prevails, the insured or beneficiary is entitled to attorney's fees under s. 627.428, F.S. Contractors are not included in s. 627.756, F.S., and cannot recover attorney fees if they file a lawsuit to recover against a payment bond.

Filing Exception for Specialty Insurers (Section 14)

In 2014, the Legislature passed CS/CS/SB 1308,[24] which implemented new elements of NAIC Model Acts related to risk-based capital, holding company systems, standard valuation, and actuarial opinions and memorandum. This was primarily in response to the financial crisis of 2008. The financial crisis was affected by the impact of common ownership and control of insurance and financial services companies, such that when one company became financially troubled or insolvent, the value and solvency of related companies also became affected. This led regulators to have an interest in knowing and understanding the web of controlling interests among related companies. This legislation created a presumption of control in certain interests and acquisitions among related companies.

While not a portion of a model act, the 2014 bill allowed insurers to overcome the presumption of control by either filing a disclaimer of control on a form prescribed by OIR or by providing a copy of the applicable Schedule 13G on file with the federal Securities and Exchange Commission (SEC).

[19] BLACK'S LAW DICTIONARY (10th ed. 2014).
[20] *See* Section 624.606(1)(a), F.S. ("'Surety insurance' includes: (a) A contract bond, including a bid, payment, or maintenance bond, or a performance bond, which guarantees the execution of a contract other than a contract of indebtedness or other monetary obligation[.]"). *See also* BLACK'S LAW DICTIONARY (10th ed. 2014) ("Although a surety is similar to an insurer, one important difference is that a surety often receives no compensation for assuming liability. A surety differs from a guarantor, who is liable to the creditor only if the debtor does not meet the duties owed to the creditor; the surety is directly liable.").
[21] Section 624.606(1)(a), F.S.
[22] Section 624.01, F.S. (defining that the "Insurance Code," which includes ch. 627, F.S.).
[23] Section 627.756(1), F.S.
[24] Ch. 2014-101, Laws of Fla.

After a disclaimer is filed, the insurer is relieved of any further duty to register or report under s. 628.461, F.S., unless the OIR disallows the disclaimer. Specialty insurers must meet similar requirements addressing solvency and organizational risk controls as those created for insurers; however they do not have the option of filing their SEC Schedule 13G to rebut the presumption of control.

Specialty insurers are defined as:[25]
- Motor vehicle service agreement companies;
- Home warranty associations;
- Service warranty associations;
- Prepaid limited health service organizations;
- Authorized health maintenance organizations;
- Authorized prepaid health clinics;
- Legal expense insurance corporations;
- Providers licensed to operate a facility that undertakes to provide continuing care;
- Multiple-employer welfare arrangements;
- Premium finance companies; and
- Corporations authorized to accept donor annuity agreements.

Own-Risk and Solvency Assessment (Section 15)

The Risk Management and Own Risk and Solvency Assessment (ORSA) Model Act by the National Association of Insurance Commissioners requires insurers to conduct their own internal assessment of all reasonably foreseeable and relevant material risks (e.g., underwriting, credit, market) potentially affecting their ability to meet policyholder obligations. This information will provide regulators with a more comprehensive view of the ability of an insurer to withstand financial stress. Florida adopted portions of the model act in 2016.[26]

Section 628.8015, F.S., requires insurers or insurance groups to:
- Maintain a risk management framework for identifying, assessing, monitoring, managing, and reporting on its material, relevant risks;
- Conduct an ORSA at least annually (and whenever there have been significant changes to the risk profile of the insurer or the insurance group);
- File an ORSA summary report with the appropriate regulator; and
- File a corporate governance annual disclosure with the OIR.

ORSA documents and corporate governance reports are generally exempt from disclosure as public records.[27] In addition, the filings and related documents are privileged such that they may not be produced in response to a subpoena or other discovery directed to the OIR. Any such filings and related documents, if obtained from the OIR, are not admissible in evidence in any private civil action.[28]

[25] Section 627.4615(1), F.S.
[26] Chapter 2016-206, Laws of Florida.
[27] Section 624.4212(3), F.S.
[28] Section 628.8015(4), F.S.

Reciprocal Insurance Reserve Requirements (Section 16)

Reciprocal insurance is a risk-pooling alternative to stock or mutual insurance.[29] Reciprocal insurance involves an exchange of reciprocal agreements of indemnity among participants who are known as "subscribers."[30] The subscribers generally have something in common. There are currently four companies active in Florida and licensed as reciprocal insurers under s. 629.401, F.S.[31]

The agreements of indemnity are exchanged through an attorney-in-fact, whose powers are set forth by the subscribers.[32] "In general, the attorney in fact manages the reciprocal's finances and handles underwriting, claims administration and investments."[33]

Twenty-five or more persons domiciled in Florida may organize a domestic reciprocal insurer and apply to OIR for authority to transact insurance.[34] Reciprocal insurers may transact any kind of insurance other than life or title.[35]

Reciprocal insurers offering property insurance are required to maintain an unearned premium[36] reserve consistent with the requirement generally applicable to property insurers under the Insurance Code.[37] This reserve requirement ensures the availability of funds for transfer to loss reserves when losses are incurred during the policy period or refunds that become due before the premium is earned, among other things. Premiums ceded to reinsurers for the purchase of reinsurance may be deducted from unearned premiums.

[29] *See* Kevin Moriarty, *Twenty Things You'd Always Wanted to Know about Reciprocals (But May Not Have Thought to Ask)*, THE RISK RETENTION REPORTER, July 2003.
[30] Sections 629.011 and 629.021, F.S.
[31] https://www.floir.com/CompanySearch/ (last visited February 7, 2018).
[32] Sections 629.011 and 629.101, F.S.
[33] *See* Kevin Moriarty, *Twenty Things You'd Always Wanted to Know about Reciprocals (But May Not Have Thought to Ask)*, THE RISK RETENTION REPORTER, July 2003.
[34] s. 629.081(1), F.S.
[35] s. 629.041(1), F.S.
[36] "Unearned premium" is the portion of a premium already received by the insurer under which protection has not yet been provided. The entire premium is not earned until the policy period expires, even though premiums are typically paid in advance. https://www.iii.org/resource-center/iii-glossary (last visited February 7, 2018).
[37] s. 625.051, F.S.

Section 625.051, F.S., requires property insurers to retain unearned premiums on reserve in the following proportions based upon the length of the policy period, as follows:

Policy Term	Proportion Required to be Reserved	
1 year or less		1/2
2 years	1st year	3/4
	2nd year	1/4
3 years	1st year	5/6
	2nd year	1/2
	3rd year	1/6
4 years	1st year	7/8
	2nd year	5/8
	3rd year	3/8
	4th year	1/8
5 years	1st year	9/10
	2nd year	7/10
	3rd year	1/2
	4th year	3/10
	5th year	1/10
Over 5 years		pro rata

In the alternative, insurers are allowed to calculate unearned premium reserves on a monthly or more frequent pro rata basis.[38] Reciprocal insurers must calculate unearned premium reserves on a monthly or more frequent basis.[39]

NAIC has developed a model act for regulation of reciprocals. Section 7., Reserves, of NAIC Model Act 356, Model Indemnity Contracts Act,[40] provides for an unearned premium reserve, as follows:

> There shall at all times be maintained as a reserve a sum in cash or convertible securities equal to fifty percent (50%) of the net annual deposits collected and credited to the accounts of the subscribers on policies having one year or less to run and pro rata on those for longer periods. Net annual deposits shall be construed to mean the advance payments of subscribers after deducting the amounts specifically provided in the subscribers' agreements, for expenses. The sum shall at no time be less than $25,000, and if at any time fifty percent (50%) of the deposits so collected and credited shall not equal that amount, then the subscribers, or their attorney for them, shall make up any deficiency.

[38] Section 625.051(3), F.S.
[39] Section 629.401(6)(b)24., F.S.
[40] http://www.naic.org/store/free/MDL-356.pdf (last visited February 7, 2018).

Delivery of Policies by Motor Vehicle Service Agreement Companies and Health Maintenance Organizations (Sections 17 and 18)

The law requires most insurance policies[41] to be mailed or delivered to the insured (policyholder) within 60 days after the insurance takes effect.[42] Insurance policies are typically only delivered when the policy is issued and are not delivered each time the policy is renewed.

Insurers are allowed to post insurance policies not containing policyholder personal identifiable information for certain types of insurance on the insurer's website instead of mailing or delivering the policy to the insured. Only policies for property and casualty insurance are allowed to be posted online. Casualty insurance includes automobile policies, workers' compensation policies, liability policies, and malpractice policies, among others.[43] Property insurance policies include homeowner's, tenant's, condominium unit owner's, mobile home owner's, condominium association, and commercial business property insurance policies.[44] The policy information posted online is general in nature.

If an insurer opts to post an insurance policy online instead of mailing it, the policy must be easily accessible on the insurer's website and posted in a format that allows the policy to be printed by the policyholder free of charge. Insurers posting policies on their website must notify each policyholder of their right to request and obtain a paper or electronic copy of the policy without charge, but policyholder consent is not required for an insurer to post an insurance policy online. Insurers must also notify policyholders of this right if the insurer changes a policy. Insurers posting policies online must archive expired policies for 5 years on the insurer's website and archived policies must be available to policyholders at their request.

III. Effect of Proposed Changes:

Foreign Insurers (Sections 1 and 2)

Section 1 amends s. 625.151, F.S., to provide that its valuation requirements do not apply to stock of a subsidiary corporation or related entities of a foreign insurer if such stock meets the valuation requirements under the laws of that insurer's state of domicile and if that state is a member of the National Association of Insurance Commissioners (NAIC).

Section 2 amends s. 625.325, F.S., to make similar changes. It requires that the investments of a foreign insurer in its subsidiaries or related companies must be permitted under the laws of the foreign insurer's state of domicile; and either be:

- Assigned a rating of 1, 2, or 3 by the National Association of Insurance Commissioners' Securities Valuation Office; or
- Assigned a rating by a nationally recognized statistical rating organization that would be equivalent to a rating of 1, 2, or 3 by the National Association of Insurance Commissioners' Securities Valuation Office.

[41] Section 627.402, F.S., defines policy to include endorsements, riders, and clauses.
[42] Section 627.421, F.S.
[43] Section 624.605, F.S.
[44] Sections 624.604 and 627.4025, F.S.

The Securities Valuation Office (SVO) is responsible for the day-to-day credit quality assessment and valuation of securities owned by state regulated insurance companies. The SVO conducts credit analysis on these securities for the purpose of assigning an NAIC designation. These designations are produced for the benefit of NAIC members who may utilize them as part of the member's monitoring of the financial condition of its domiciliary insurers.[45] An NAIC rating of 1 means the obligation should be eligible for the most favorable treatment provided under the NAIC Financial Conditions Framework. An NAIC rating of 2 means that credit risk is low but may increase in the intermediate future and the issuer's credit profile are reasonably stable. It should be eligible for relatively favorable treatment under the NAIC Financial Conditions Framework. A rating of 3 is assigned to obligations of medium quality. Credit risk is intermediate. Ratings of 4, 5, and 6 means the obligations are low quality.[46]
Nationally recognized statistical rating organizations (NRSRO) are credit rating agencies that provide an assessment of the creditworthiness of a company or a financial instrument. In 2006, Congress provided the Securities and Exchange Commission with the authority to establish a registration and oversight program for credit rating agencies registered as NRSROs.[47] The NRSROs registered with the SEC are:

- A.M. Best Rating Services, Inc.
- DBRS, Inc.
- Egan-Jones Ratings Co.
- Fitch Ratings, Inc.
- HR Ratings de México, S.A. de C.V.
- Japan Credit Rating Agency, Ltd.
- Kroll Bond Rating Agency, Inc.
- Moody's Investors Service, Inc.
- Morningstar Credit Ratings, LLC
- S&P Global Ratings[48]

The chart containing ratings equivalent to SVO ratings is found here: http://www.naic.org/documents/svo_naic_aro.pdf (last visited January 29, 2018).

The changes made by sections 1 and 2 of the bill would make Florida's requirements related to investments held by foreign insurers conform to the requirements of the state where the foreign insurer is domiciled. The Office of Insurance Regulation bill analysis noted that "[l]owering Florida's investment limitation standards to those of the domiciliary state would reduce protection for Florida policyholders and weaken effective solvency regulation."[49]

Insurance Adjuster Licensure Examination (Section 3)

The bill provides an exemption to the all-lines adjuster licensing exam requirements to individuals who receive a Claims Adjuster Certified Professional (CACP) designation from

[45] http://www.naic.org/svo.htm (last visited January 29, 2018).
[46] http://www.naic.org/documents/svo_naic_public_listing.pdf?353 (last visited February 2, 2018).
[47] https://www.sec.gov/ocr/ocr-learn-nrsros.html (last visited January 29, 2018).
[48] *Id*.
[49] Office of Insurance Regulation, *Bill Analysis of SB 784* (on file with the Senate Committee on Banking and Insurance.

WebCE, Inc. The bill also authorizes the DFS to accept similar designations from similar entities to those listed in the statute for purposes for the examination exemption.

Surplus Lines Insurance (Sections 4, 5, and 6)

Section 4 amends s. 626.914, F.S., to provide that the surplus lines agent fulfills the "diligent effort" requirement if the agent seeks coverage from and is rejected by at least one authorized insurer if the residential structure has a dwelling replacement cost of at least $ $700,000. Currently, the property must have a $1 million dwelling replacement cost in order for the agent to only have to seek coverage from and be rejected by one authorized insurer.

Section 5 repeals s. 626.918(2)(a), F.S., requiring surplus lines insurers to request eligibility from the FSLSO.

Section 6 of the bill lowers the surplus lines premium tax rate to 4.936 percent instead of the current 5 percent. It allows the tax to exceed the tax rate where the risk is located.

Privacy Disclosures (Section 7)

The bill allows the DFS and the Financial Services Commission to adopt into rule the changes made by the FAST Act to federal standards governing the use of a consumer's nonpublic personal financial and health information. It provides that companies that have not made changes to certain privacy policies are not required to send an annual notice of changes. If changes are made, the companies must notify customers.

Execution of Insurance Policies (Section 8)

Section 8 amends s.627.416, F.S., to provide that an insurer may elect to issue an insurance policy without it being executed by one of the specified insurer representatives. If such a policy is issued, it is not invalid despite not being executed.

Notice of Change in Policy Terms (Section 9)

The bill requires that an insurer summarize policy changes on the required notice upon renewal, rather than merely issuing a properly titled notice.

Mediation through DFS (Section 10)

The bill amends s. 627.7015, F.S., to provide that a policyholder, as first-party claimant, a third party, as assignee of policy benefits, or the insurer may request mediation through DFS. An insurer may participate in mediation requested by a third party, as assignee of policy benefits, but is not required to participate in a mediation requested by an assignee of policy benefits. The bill also makes stylistic changes by replacing the term "insured" with the term "policyholder." The terms are often used interchangeably.

Proof of Mailing (Section 11)

Section 11 amends s. 627.728, F.S., to provide that an automobile insurer may rely on United States postal proof of mailing, certified or registered mailing, or other mailing using the Intelligent Mail barcode or other similar tracking method used or approved by the United States Postal Service as sufficient proof of:

- notice of cancellation;
- notice of intention not to renew, or of reasons for cancellation; or
- notice of the intention of the insurer to issue a policy by an insurer under the same ownership or management was sent to the first-named insured at the address shown in the policy.

Bonds for Construction Contracts (Sections 12 and 13)

Section 12 amends s. 627.756(1), F.S., of the Insurance Code to extend the ability to collect attorney's fees against an insurer under s. 627.428(1), F.S., to contractors by also deeming them an insured or beneficiary. This change will apply when a contractor successfully enforces a claim against the bond of a subcontractor that has breached a contract with the contractor. **Section 13** provides that this provision applies to payment or performance bonds issued on or after October 1, 2018.

Specialty Insurers (Section 14)

Section 14 amends s. 628.4615, F.S., to add viatical settlement providers to the list of specialty insurers and allows any specialty insurer to overcome the presumption of control by filing with OIR a disclaimer of control on an OIR form or a copy of their SEC Schedule 13G.

Own-Risk and Solvency Assessment (Section 15)

Section 15 amends s. 628.8015, F.S., to expand the confidentiality of documents submitted to the OIR under ORSA requirements. The bill provides that such documents may not be admitted as evidence in a private civil action regardless of the source of the documents, rather than only when they are obtained from the OIR.

Reciprocal Insurer Reserve Requirements (Section 16)

Section 16 amends s. 629.401, F.S., to revise the unearned premium reserve requirement that must be met by a reciprocal insurer, regardless of the line of insurance underwritten. The reciprocal insurer must retain 50 percent of "net written premiums" on policies having a policy period of 1 year or less. "Net written premiums" means premium payments made or due from subscribers after deducting expenses specified in the subscriber's agreement, including reinsurance costs and subscriber fees. To take the deduction from "net written premiums" for subscriber fees, the power of attorney agreement must contain an explicit provision to return subscriber fees on a pro rata basis for cancelled policies. The bill requires an unearned premium reserve of $100,000, at all times, and provides a mechanism to return the reserve to that amount if it is not maintained at the required amount.

Delivery of Policies by Motor Vehicle Service Agreement Companies and Health Maintenance Organizations (Sections 17 and 18)

The bill requires motor vehicle service agreement companies and health maintenance organizations (HMO) to deliver motor vehicle service agreements and HMO contracts in compliance with the standards applicable to insurers. This changes the timeline for delivery of a motor vehicle service agreement from 45 days to 60 days and for HMO contracts from 10 days from enrollment to 60 days. It also allows posting of the non-personal portions of agreements and contracts, as applicable, on a website in the manner allowed for policies by insurers. The personal portions of these documents would be delivered by other allowable means, usually mailing.

Effective Date (Section 19)

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Changes to the mailing requirement in section 11 could result in cost savings to insurers.

C. Government Sector Impact:

The Revenue Estimating Conference does not anticipate a significant impact from the surplus line tax change in section 6 of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 625.151, 625.325, 626.221, 626.914, 626.932, 626.9651, 627.416, 627.41341, 627.7015, 627.728, 627.756, 628.4615, 628.8015, 629.401, 634.121, and 641.3107.

The bill repeals paragraph 626.918(2)(a) 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 February 6, 2018:
The CS removed provisions that:

- Provides that a third-party vendor, as an assignee of policy benefits, is not a consumer for purposes of consumer complaints received by the DFS Division of Consumer Services;
- Provides that complaints from third-party vendors as assignees of policy benefits will not count as complaints for purposes of the complaint ratio calculations;
- Provides that the reporting of certain information used by the Department of Financial Services to prevent insurance fraud is not mandatory;
- Provides that the insurance nonjoinder statute applies to surplus lines insurers;
- Allows the Office of Insurance Regulation (OIR) to waive the requirement that a surplus lines insurer has operated for the previous 3 years before seeking eligibility to operate in Florida if the insurer provides a product or service not readily available to Florida consumers or has operated successfully for a period of at least 1 year next preceding and has capital and surplus of not less than $30 million;
- Increases the ability of motor vehicle insurers to exclude coverage when drivers are engaged in transportation network company activities; and
- Provides that any person who sells prepaid limited health service contracts that only cover the cost of transportation provided by an air ambulance service is not required to be licensed as a health insurance agent.

The CS adds provisions that:

- Provide if an applicant for licensure as an all-lines adjuster is certified as a Claims Adjuster Certified Professional from WebCE, Inc., the applicant does not have to take the adjuster examination;
- Repeal a requirement that surplus lines insurers request eligibility from the Florida Surplus Lines Service Office;
- Provide a uniform surplus lines tax of 4.936 percent;

- Lower from $1 million to $700,000 the threshold for exporting a homeowner's property insurance risk to a surplus lines insurer following a single coverage rejection;
- Provide that an insurer may issue an insurance policy without certain signatures;
- Require that a notice of policy change summarize the changes made to the policy before renewal;
- Revise unearned premium reserve requirements for reciprocal insurers; and
- Allow for electronic posting of certain policy information by health maintenance organizations and motor vehicle service agreement companies and increases the time for delivering such contracts.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2018	.	
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	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (c) is added to subsection (3) of section 625.151, Florida Statutes, to read:

625.151 Valuation of other securities.—

(3) Stock of a subsidiary corporation of an insurer may ~~shall~~ not be valued at an amount in excess of the net value thereof as based upon those assets only of the subsidiary which

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would be eligible under part II for investment of the funds of the insurer directly.

(c) This subsection does not apply to stock of a subsidiary corporation or related entities of a foreign insurer which is permissible under the laws of its state of domicile, if the state of domicile is a member of the National Association of Insurance Commissioners.

Section 2. Subsection (7) is added to section 625.325, Florida Statutes, to read:

625.325 Investments in subsidiaries and related corporations.—

(7) APPLICABILITY.-This section does not apply to a foreign insurer's investments in its subsidiaries or related corporations if:

(a) The foreign insurer is domiciled in a state that is a member of the National Association of Insurance Commissioners (NAIC).

(b) Such investments in the foreign insurer's subsidiaries or related corporations are:

1. Permitted under the laws of the foreign insurer's state of domicile.

2.a. Assigned a rating of 1, 2, or 3 by the NAIC's Securities Valuation Office (SVO); or

b. Qualify for the NAIC's filing exemption rule and assigned a rating by a nationally recognized statistical rating organization which would be equivalent to a rating of 1, 2, or 3 by the SVO.

Section 3. Paragraph (j) of subsection (2) of section 626.221, Florida Statutes, is amended to read:

626.221 Examination requirement; exemptions.—

(2) However, an examination is not necessary for any of the following:

(j) An applicant for license as an all-lines adjuster who has the designation of Accredited Claims Adjuster (ACA) from a regionally accredited postsecondary institution in this state, Associate in Claims (AIC) from the Insurance Institute of America, Professional Claims Adjuster (PCA) from the Professional Career Institute, Professional Property Insurance Adjuster (PPIA) from the HurriClaim Training Academy, Certified Adjuster (CA) from ALL LINES Training, Certified Claims Adjuster (CCA) from AE21 Incorporated, Claims Adjuster Certified Professional (CACP) from WebCE, Inc., or Universal Claims Certification (UCC) from Claims and Litigation Management Alliance (CLM) whose curriculum has been approved by the department and which includes comprehensive analysis of basic property and casualty lines of insurance and testing at least equal to that of standard department testing for the all-lines adjuster license. The department shall adopt rules establishing standards for the approval of curriculum.

Section 4. Subsection (4) of section 626.914, Florida Statutes, is amended to read:

626.914 Definitions.—As used in this Surplus Lines Law, the term:

(4) "Diligent effort" means seeking coverage from and having been rejected by at least three authorized insurers currently writing this type of coverage and documenting these rejections. However, if the residential structure has a dwelling replacement cost of $700,000 ~~$1 million~~ or more, the term means


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seeking coverage from and having been rejected by at least one authorized insurer currently writing this type of coverage and documenting this rejection.

Section 5. Paragraph (a) of subsection (2) of section 626.918, Florida Statutes, is repealed.

Section 6. Subsections (1) and (3) of section 626.932, Florida Statutes, are amended to read:

626.932 Surplus lines tax.—

(1) The premiums charged for surplus lines coverages are subject to a premium receipts tax of 4.936 ~~5~~ percent of all gross premiums charged for such insurance. The surplus lines agent shall collect from the insured the amount of the tax at the time of the delivery of the cover note, certificate of insurance, policy, or other initial confirmation of insurance, in addition to the full amount of the gross premium charged by the insurer for the insurance. The surplus lines agent is prohibited from absorbing such tax or, as an inducement for insurance or for any other reason, rebating all or any part of such tax or of his or her commission.

(3) If a surplus lines policy covers risks or exposures only partially in this state and the state is the home state as defined in the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), the tax payable must ~~shall~~ be computed on the gross premium. ~~The tax must not exceed the tax rate where the risk or exposure is located.~~

Section 7. Section 626.9651, Florida Statutes, is amended to read:

626.9651 Privacy.—The department and commission shall each adopt rules consistent with other provisions of the Florida

Insurance Code to govern the use of a consumer's nonpublic personal financial and health information. These rules must be based on, consistent with, and not more restrictive than the Privacy of Consumer Financial and Health Information Regulation, adopted September 26, 2000, by the National Association of Insurance Commissioners; however, the rules must permit the use and disclosure of nonpublic personal health information for scientific, medical, or public policy research, in accordance with federal law. In addition, these rules must be consistent with, and not more restrictive than, the standards contained in Title V of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102, as amended in Title LXXV of the Fixing America's Surface Transportation (FAST) Act, Pub. L. No. 114-94. If the office determines that a health insurer or health maintenance organization is in compliance with, or is actively undertaking compliance with, the consumer privacy protection rules adopted by the United States Department of Health and Human Services, in conformance with the Health Insurance Portability and Affordability Act, that health insurer or health maintenance organization is in compliance with this section.

Section 8. Subsection (1) of section 627.416, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

627.416 Execution of policies.—

(1) Except as set forth in subsection (4), every insurance policy must ~~shall~~ be executed in the name of and on behalf of the insurer by its officer, attorney in fact, employee, or representative duly authorized by the insurer.

(4) An insurer may elect to issue an insurance policy that

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is not executed by an officer, attorney in fact, employee, or representative, provided that such policy may not be rendered invalid by reason of the lack of execution thereof.

Section 9. Subsection (2) of section 627.43141, Florida Statutes, is amended to read:

627.43141 Notice of change in policy terms.—

(2) A renewal policy may contain a change in policy terms. If such change occurs, the insurer shall give the named insured advance written notice summarizing ~~of~~ the change, which may be enclosed along with the written notice of renewal premium required under ss. 627.4133 and 627.728 or sent separately within the timeframe required under the Florida Insurance Code for the provision of a notice of nonrenewal to the named insured for that line of insurance. The insurer must also provide a sample copy of the notice to the named insured's insurance agent before or at the same time that notice is provided to the named insured. Such notice must ~~shall~~ be entitled "Notice of Change in Policy Terms."

Section 10. Subsections (1), (3), (6), and (9) of section 627.7015, Florida Statutes, are amended to read:

627.7015 Alternative procedure for resolution of disputed property insurance claims.—

(1) This section sets forth a nonadversarial alternative dispute resolution procedure for a mediated claim resolution conference prompted by the need for effective, fair, and timely handling of property insurance claims. There is a particular need for an informal, nonthreatening forum for helping parties who elect this procedure to resolve their claims disputes because most homeowner and commercial residential insurance

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policies obligate policyholders to participate in a potentially expensive and time-consuming adversarial appraisal process before litigation. The procedure set forth in this section is designed to bring the parties together for a mediated claims settlement conference without any of the trappings or drawbacks of an adversarial process. Before resorting to these procedures, policyholders and insurers are encouraged to resolve claims as quickly and fairly as possible. This section is available with respect to claims under personal lines and commercial residential policies before commencing the appraisal process, or before commencing litigation. Mediation may be requested only by the policyholder, as a first-party claimant; a third party, as assignee of the policy benefits; ~~,~~ or the insurer. However, an insurer is not required to participate in any mediation requested by a third party assignee of policy benefits. If requested by the policyholder, participation by legal counsel is permitted. Mediation under this section is also available to litigants referred to the department by a county court or circuit court. This section does not apply to commercial coverages, to private passenger motor vehicle insurance coverages, or to disputes relating to liability coverages in policies of property insurance.

(3) The costs of mediation must ~~shall~~ be reasonable, and the insurer shall bear all of the cost of conducting mediation conferences, except as otherwise provided in this section. If the policyholder ~~an insured~~ fails to appear at the conference, the conference must ~~shall~~ be rescheduled upon the policyholder's ~~insured's~~ payment of the costs of a rescheduled conference. If the insurer fails to appear at the conference, the insurer must


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~~shall~~ pay the policyholder's ~~insured's~~ actual cash expenses incurred in attending the conference if the insurer's failure to attend was not due to a good cause acceptable to the department. An insurer will be deemed to have failed to appear if the insurer's representative lacks authority to settle the full value of the claim. The insurer shall incur an additional fee for a rescheduled conference necessitated by the insurer's failure to appear at a scheduled conference. The fees assessed by the administrator must ~~shall~~ include a charge necessary to defray the expenses of the department related to its duties under this section and must ~~shall~~ be deposited in the Insurance Regulatory Trust Fund.

(6) Mediation is nonbinding; however, if a written settlement is reached, the policyholder ~~insured~~ has 3 business days within which the policyholder ~~insured~~ may rescind the settlement unless the policyholder ~~insured~~ has cashed or deposited any check or draft disbursed to the policyholder ~~insured~~ for the disputed matters as a result of the conference. If a settlement agreement is reached and is not rescinded, it is ~~shall be~~ binding and acts ~~act~~ as a release of all specific claims that were presented in that mediation conference.

(9) For purposes of this section, the term "claim" refers to any dispute between an insurer and a policyholder relating to a material issue of fact other than a dispute:

(a) With respect to which the insurer has a reasonable basis to suspect fraud;

(b) When ~~Where~~, based on agreed-upon facts as to the cause of loss, there is no coverage under the policy;

(c) With respect to which the insurer has a reasonable

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basis to believe that the policyholder has intentionally made a material misrepresentation of fact which is relevant to the claim, and the entire request for payment of a loss has been denied on the basis of the material misrepresentation;

(d) With respect to which the amount in controversy is less than $500, unless the parties agree to mediate a dispute involving a lesser amount; or

(e) With respect to a windstorm or hurricane loss that does not comply with s. 627.70132.

Section 11. Subsection (5) of section 627.728, Florida Statutes, is amended to read:

627.728 Cancellations; nonrenewals.—

(5) United States postal proof of mailing, ~~or~~ certified or registered mailing, or other mailing using the Intelligent Mail barcode or other similar tracking method used or approved by the United States Postal Service of notice of cancellation, of intention not to renew, or of reasons for cancellation, or of the intention of the insurer to issue a policy by an insurer under the same ownership or management, to the first-named insured at the address shown in the policy is ~~shall be~~ sufficient proof of notice.

Section 12. Subsections (1) and (7) of section 628.4615, Florida Statutes, are amended, present subsections (11) through (14) of that section are redesignated as subsections (12) through (15), respectively, and a new subsection (11) is added to that section, to read:

628.4615 Specialty insurers; acquisition of controlling stock, ownership interest, assets, or control; merger or consolidation.—

(1) For the purposes of this section, the term "specialty insurer" means any person holding a license or certificate of authority as:

(a) A motor vehicle service agreement company authorized to issue motor vehicle service agreements as those terms are defined in s. 634.011;

(b) A home warranty association authorized to issue "home warranties" as those terms are defined in s. 634.301;

(c) A service warranty association authorized to issue "service warranties" as those terms are defined in s. 634.401(13) and (14);

(d) A prepaid limited health service organization authorized to issue prepaid limited health service contracts, as those terms are defined in chapter 636;

(e) An authorized health maintenance organization operating pursuant to s. 641.21;

(f) An authorized prepaid health clinic operating pursuant to s. 641.405;

(g) A legal expense insurance corporation authorized to engage in a legal expense insurance business pursuant to s. 642.021;

(h) A provider that is licensed to operate a facility that undertakes to provide continuing care as those terms are defined in s. 651.011;

(i) A multiple-employer welfare arrangement operating pursuant to ss. 624.436-624.446;

(j) A premium finance company authorized to finance insurance premiums pursuant to s. 627.828; ~~or~~

(k) A corporation authorized to accept donor annuity


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agreements pursuant to s. 627.481; or

(l) A viatical settlement provider authorized to do business in this state under part X of chapter 626.

(7) The office may disapprove any acquisition subject to ~~the provisions of~~ this section by any person or any affiliated person of such person who:

(a) Willfully violates this section;

(b) In violation of an order of the office issued pursuant to subsection (12) ~~(11)~~, fails to divest himself or herself of any stock or ownership interest obtained in violation of this section or fails to divest himself or herself of any direct or indirect control of such stock or ownership interest, within 25 days after such order; or

(c) In violation of an order issued by the office pursuant to subsection (12) ~~(11)~~, acquires an additional stock or ownership interest in a specialty insurer or controlling company or direct or indirect control of such stock or ownership interest, without complying with this section.

(11) A person may rebut a presumption of control by filing a disclaimer of control with the office on a form prescribed by the commission. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the specialty insurer as well as the basis for disclaiming the affiliation. In lieu of such form, a person or acquiring party may file with the office a copy of a Schedule 13G filed with the Securities and Exchange Commission pursuant to Rule 13d-1(b) or (c), 17 C.F.R. s. 240.13d-1, under the Securities Exchange Act of 1934, as amended. After a disclaimer has been filed, the specialty insurer is relieved of any duty to register or report

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under this section which may arise out of the specialty insurer's relationship with the person unless the office disallows the disclaimer.

Section 13. Subsection (4) of section 628.8015, Florida Statutes, is amended to read:

628.8015 Own-risk and solvency assessment; corporate governance annual disclosure.—

(4) CONFIDENTIALITY.—The required filings and related documents submitted pursuant to subsections (2) and (3) are privileged such that they may not be produced in response to a subpoena or other discovery directed to the office, and any such filings and related documents~~, if obtained from the office,~~ are not admissible in evidence in any private civil action. However, the department or office may use these filings and related documents in the furtherance of any regulatory or legal action brought against an insurer as part of the official duties of the department or office. A waiver of any applicable claim of privilege in these filings and related documents may not occur because of a disclosure to the office under this section, because of any other provision of the Insurance Code, or because of sharing under s. 624.4212. The office or a person receiving these filings and related documents, while acting under the authority of the office, or with whom such filings and related documents are shared pursuant to s. 624.4212, is not permitted or required to testify in any private civil action concerning any such filings or related documents.

Section 14. Paragraph (b) of subsection (6) of section 629.401, Florida Statutes, is amended to read:

629.401 Insurance exchange.—

(6)

(b) In addition to the insurance laws specified in paragraph (a), the office shall regulate the exchange pursuant to the following powers, rights, and duties:

1. General examination powers.—The office shall examine the affairs, transactions, accounts, records, and assets of any security fund, exchange, members, and associate brokers as often as it deems advisable. The examination may be conducted by the accredited examiners of the office at the offices of the entity or person being examined. The office shall examine in like manner each prospective member or associate broker applying for membership in an exchange.

2. Office approval and applications of underwriting members.—No underwriting member shall commence operation without the approval of the office. Before commencing operation, an underwriting member shall provide a written application containing:

a. Name, type, and purpose of the underwriting member.

b. Name, residence address, business background, and qualifications of each person associated or to be associated in the formation or financing of the underwriting member.

c. Full disclosure of the terms of all understandings and agreements existing or proposed among persons so associated relative to the underwriting member, or the formation or financing thereof, accompanied by a copy of each such agreement or understanding.

d. Full disclosure of the terms of all understandings and agreements existing or proposed for management or exclusive agency contracts.

3. Investigation of underwriting member applications.—In connection with any proposal to establish an underwriting member, the office shall make an investigation of:

a. The character, reputation, financial standing, and motives of the organizers, incorporators, or subscribers organizing the proposed underwriting member.

b. The character, financial responsibility, insurance experience, and business qualifications of its proposed officers.

c. The character, financial responsibility, business experience, and standing of the proposed stockholders and directors, or owners.

4. Notice of management changes.—An underwriting member shall promptly give the office written notice of any change among the directors or principal officers of the underwriting member within 30 days after such change. The office shall investigate the new directors or principal officers of the underwriting member. The office’s investigation shall include an investigation of the character, financial responsibility, insurance experience, and business qualifications of any new directors or principal officers. As a result of the investigation, the office may require the underwriting member to replace any new directors or principal officers.

5. Alternate financial statement.—In lieu of any financial examination, the office may accept an audited financial statement.

6. Correction and reconstruction of records.—If the office finds any accounts or records to be inadequate, or inadequately kept or posted, it may employ experts to reconstruct, rewrite,

post, or balance them at the expense of the person or entity being examined if such person or entity has failed to maintain, complete, or correct such records or accounts after the office has given him or her or it notice and reasonable opportunity to do so.

7. Obstruction of examinations.—Any person or entity who or which willfully obstructs the office or its examiner in an examination is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

8. Filing of annual statement.—Each underwriting member shall file with the office a full and true statement of its financial condition, transactions, and affairs. The statement shall be filed on or before March 1 of each year, or within such extension of time as the office for good cause grants, and shall be for the preceding calendar year. The statement shall contain information generally included in insurer financial statements prepared in accordance with generally accepted insurance accounting principles and practices and in a form generally utilized by insurers for financial statements, sworn to by at least two executive officers of the underwriting member. The form of the financial statements shall be the approved form of the National Association of Insurance Commissioners or its successor organization. The commission may by rule require each insurer to submit any part of the information contained in the financial statement in a computer-readable form compatible with the office's electronic data processing system. In addition to information furnished in connection with its annual statement, an underwriting member must furnish to the office as soon as reasonably possible such information about its transactions or

affairs as the office requests in writing. All information furnished pursuant to the office's request must be verified by the oath of two executive officers of the underwriting member.

9. Record maintenance.—Each underwriting member shall have and maintain its principal place of business in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary for or suitable to the kind or kinds of insurance transacted.

10. Examination of agents.—If the department has reason to believe that any agent, as defined in s. 626.015 or s. 626.914, has violated or is violating any provision of the insurance law, or upon receipt of a written complaint signed by any interested person indicating that any such violation may exist, the department shall conduct such examination as it deems necessary of the accounts, records, documents, and transactions pertaining to or affecting the insurance affairs of such agent.

11. Written reports of office.—The office or its examiner shall make a full and true written report of any examination. The report shall contain only information obtained from examination of the records, accounts, files, and documents of or relative to the person or entity examined or from testimony of individuals under oath, together with relevant conclusions and recommendations of the examiner based thereon. The office shall furnish a copy of the report to the person or entity examined not less than 30 days prior to filing the report in its office. If such person or entity so requests in writing within such 30-day period, the office shall grant a hearing with respect to the report and shall not file the report until after the hearing and

after such modifications have been made therein as the office deems proper.

12. Admissibility of reports.—The report of an examination when filed shall be admissible in evidence in any action or proceeding brought by the office against the person or entity examined, or against his or her or its officers, employees, or agents. The office or its examiners may at any time testify and offer other proper evidence as to information secured or matters discovered during the course of an examination, whether or not a written report of the examination has been either made, furnished, or filed in the office.

13. Publication of reports.—After an examination report has been filed, the office may publish the results of any such examination in one or more newspapers published in this state whenever it deems it to be in the public interest.

14. Consideration of examination reports by entity examined.—After the examination report of an underwriting member has been filed, an affidavit shall be filed with the office, not more than 30 days after the report has been filed, on a form furnished by the office and signed by the person or a representative of any entity examined, stating that the report has been read and that the recommendations made in the report will be considered within a reasonable time.

15. Examination costs.—Each person or entity examined by the office shall pay to the office the expenses incurred in such examination.

16. Exchange costs.—An exchange shall reimburse the office for any expenses incurred by it relating to the regulation of the exchange and its members, except as specified in

subparagraph 15.

17. Powers of examiners.—Any examiner appointed by the office, as to the subject of any examination, investigation, or hearing being conducted by him or her, may administer oaths, examine and cross-examine witnesses, and receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance and testimony, and require by subpoena the production of books, papers, records, files, correspondence, documents, or other evidence which the examiner deems relevant to the inquiry. If any person refuses to comply with any such subpoena or to testify as to any matter concerning which he or she may be lawfully interrogated, the Circuit Court of Leon County or the circuit court of the county wherein such examination, investigation, or hearing is being conducted, or of the county wherein such person resides, on the office's application may issue an order requiring such person to comply with the subpoena and to testify; and any failure to obey such an order of the court may be punished by the court as a contempt thereof. Subpoenas shall be served, and proof of such service made, in the same manner as if issued by a circuit court. Witness fees and mileage, if claimed, shall be allowed the same as for testimony in a circuit court.

18. False testimony.—Any person willfully testifying falsely under oath as to any matter material to any examination, investigation, or hearing shall upon conviction thereof be guilty of perjury and shall be punished accordingly.

19. Self-incrimination.—

a. If any person asks to be excused from attending or testifying or from producing any books, papers, records,

contracts, documents, or other evidence in connection with any examination, hearing, or investigation being conducted by the office or its examiner, on the ground that the testimony or evidence required of the person may tend to incriminate him or her or subject him or her to a penalty or forfeiture, and the person notwithstanding is directed to give such testimony or produce such evidence, he or she shall, if so directed by the office and the Department of Legal Affairs, nonetheless comply with such direction; but the person shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which he or she may have so testified or produced evidence, and no testimony so given or evidence so produced shall be received against him or her upon any criminal action, investigation, or proceeding; except that no such person so testifying shall be exempt from prosecution or punishment for any perjury committed by him or her in such testimony, and the testimony or evidence so given or produced shall be admissible against him or her upon any criminal action, investigation, or proceeding concerning such perjury, nor shall he or she be exempt from the refusal, suspension, or revocation of any license, permission, or authority conferred, or to be conferred, pursuant to the insurance law.

b. Any such individual may execute, acknowledge, and file with the office a statement expressly waiving such immunity or privilege in respect to any transaction, matter, or thing specified in such statement, and thereupon the testimony of such individual or such evidence in relation to such transaction, matter, or thing may be received or produced before any judge or

justice, court, tribunal, grand jury, or otherwise; and if such testimony or evidence is so received or produced, such individual shall not be entitled to any immunity or privileges on account of any testimony so given or evidence so produced.

20. Penalty for failure to testify.—Any person who refuses or fails, without lawful cause, to testify relative to the affairs of any member, associate broker, or other person when subpoenaed and requested by the office to so testify, as provided in subparagraph 17., shall, in addition to the penalty provided in subparagraph 17., be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

21. Name selection.—No underwriting member shall be formed or authorized to transact insurance in this state under a name which is the same as that of any authorized insurer or is so nearly similar thereto as to cause or tend to cause confusion or under a name which would tend to mislead as to the type of organization of the insurer. Before incorporating under or using any name, the underwriting syndicate or proposed underwriting syndicate shall submit its name or proposed name to the office for the approval of the office.

22. Capitalization.—An underwriting member approved on or after July 2, 1987, shall provide an initial paid-in capital and surplus of $3 million and thereafter shall maintain a minimum policyholder surplus of $2 million in order to be permitted to write insurance. Underwriting members approved prior to July 2, 1987, shall maintain a minimum policyholder surplus of $1 million. After June 29, 1988, underwriting members approved prior to July 2, 1987, must maintain a minimum policyholder

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surplus of $1.5 million to write insurance. After June 29, 1989, underwriting members approved prior to July 2, 1987, must maintain a minimum policyholder surplus of $1.75 million to write insurance. After December 30, 1989, all underwriting members, regardless of the date they were approved, must maintain a minimum policyholder surplus of $2 million to write insurance. Except for that portion of the paid-in capital and surplus which shall be maintained in a security fund of an exchange, the paid-in capital and surplus shall be invested by an underwriting member in a manner consistent with ss. 625.301-625.340. The portion of the paid-in capital and surplus in any security fund of an exchange shall be invested in a manner limited to investments for life insurance companies under the Florida insurance laws.

23. Limitations on coverage written.—

a. Limit of risk.—No underwriting member shall expose itself to any loss on any one risk in an amount exceeding 10 percent of its surplus to policyholders. Any risk or portion of any risk which shall have been reinsured in an assuming reinsurer authorized or approved to do such business in this state shall be deducted in determining the limitation of risk prescribed in this section.

b. Restrictions on premiums written.—If the office has reason to believe that the underwriting member’s ratio of actual or projected annual gross written premiums to policyholder surplus exceeds 8 to 1 or the underwriting member’s ratio of actual or projected annual net premiums to policyholder surplus exceeds 4 to 1, the office may establish maximum gross or net annual premiums to be written by the underwriting member


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consistent with maintaining the ratios specified in this sub-subparagraph.

(I) Projected annual net or gross premiums shall be based on the actual writings to date for the underwriting member's current calendar year, its writings for the previous calendar year, or both. Ratios shall be computed on an annualized basis.

(II) For purposes of this sub-subparagraph, the term "gross written premiums" means direct premiums written and reinsurance assumed.

c. Surplus as to policyholders.—For the purpose of determining the limitation on coverage written, surplus as to policyholders shall be deemed to include any voluntary reserves, or any part thereof, which are not required by or pursuant to law and shall be determined from the last sworn statement of such underwriting member with the office, or by the last report or examination filed by the office, whichever is more recent at the time of assumption of such risk.

24. Unearned premium reserves.—An underwriting member must at all times maintain an unearned premium reserve equal to 50 percent of the net written premiums of the subscribers on policies having 1 year or less to run, and pro rata on those for longer periods, ~~All unearned premium reserves for business written on the exchange shall be calculated on a monthly or more frequent basis or on such other basis as determined by the office;~~ except that all premiums on any marine or transportation insurance trip risk shall be deemed unearned until the trip is terminated. For the purpose of this subparagraph, the term "net written premiums" means the premium payments made by subscribers plus the premiums due from subscribers, after deducting the

amounts specifically provided in the subscribers' agreements for expenses, including reinsurance costs and fees paid to the attorney in fact, provided that the power of attorney agreement contains an explicit provision requiring the attorney in fact to refund any unearned subscribers fees on a pro-rata basis for cancelled policies. If there is no such provision, the unearned premium reserves must be calculated without any adjustment for fees paid to the attorney in fact. If the unearned premium reserves at any time do not amount to $100,000, there must be maintained on deposit at the exchange at all times additional funds in cash or eligible securities, which, together with the unearned premium reserves, equal $100,000. In calculating the foregoing reserves, the amount of the attorney's bond, as filed with the office and as required by s. 629.121, must be included in such reserves. If at any time the unearned premium reserves are less than the foregoing requirements, the subscribers or the attorney in fact shall advance funds to make up the deficiency. Such advances must be repaid only out of the surplus of the exchange and only after receiving written approval from the office.

25. Loss reserves.—All underwriting members of an exchange shall maintain loss reserves, including a reserve for incurred but not reported claims. The reserves shall be subject to review by the office, and, if loss experience shows that an underwriting member's loss reserves are inadequate, the office shall require the underwriting member to maintain loss reserves in such additional amount as is needed to make them adequate.

26. Distribution of profits.—An underwriting member shall not distribute any profits in the form of cash or other assets

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to owners except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and realized capital gains. In any one year such payments to owners shall not exceed 30 percent of such surplus as of December 31 of the immediately preceding year, unless otherwise approved by the office. No distribution of profits shall be made that would render an underwriting member either impaired or insolvent.

27. Stock dividends.—A stock dividend may be paid by an underwriting member out of any available surplus funds in excess of the aggregate amount of surplus advanced to the underwriting member under subparagraph 29.

28. Dividends from earned surplus.—A dividend otherwise lawful may be payable out of an underwriting member's earned surplus even though the total surplus of the underwriting member is then less than the aggregate of its past contributed surplus resulting from issuance of its capital stock at a price in excess of the par value thereof.

29. Borrowing of money by underwriting members.—

a. An underwriting member may borrow money to defray the expenses of its organization, provide it with surplus funds, or for any purpose of its business, upon a written agreement that such money is required to be repaid only out of the underwriting member's surplus in excess of that stipulated in such agreement. The agreement may provide for interest not exceeding 15 percent simple interest per annum. The interest shall or shall not constitute a liability of the underwriting member as to its funds other than such excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in

connection with any such loan. The use of any surplus note and any repayments thereof shall be subject to the approval of the office.

b. Money so borrowed, together with any interest thereon if so stipulated in the agreement, shall not form a part of the underwriting member's legal liabilities except as to its surplus in excess of the amount thereof stipulated in the agreement, nor be the basis of any setoff; but until repayment, financial statements filed or published by an underwriting member shall show as a footnote thereto the amount thereof then unpaid, together with any interest thereon accrued but unpaid.

30. Liquidation, rehabilitation, and restrictions.—The office, upon a showing that a member or associate broker of an exchange has met one or more of the grounds contained in part I of chapter 631, may restrict sales by type of risk, policy or contract limits, premium levels, or policy or contract provisions; increase surplus or capital requirements of underwriting members; issue cease and desist orders; suspend or restrict a member's or associate broker's right to transact business; place an underwriting member under conservatorship or rehabilitation; or seek an order of liquidation as authorized by part I of chapter 631.

31. Prohibited conduct.—The following acts by a member, associate broker, or affiliated person shall constitute prohibited conduct:

a. Fraud.

b. Fraudulent or dishonest acts committed by a member or associate broker prior to admission to an exchange, if the facts and circumstances were not disclosed to the office upon

application to become a member or associate broker.

c. Conduct detrimental to the welfare of an exchange.

d. Unethical or improper practices or conduct, inconsistent with just and equitable principles of trade as set forth in, but not limited to, ss. 626.951-626.9641 and 626.973.

e. Failure to use due diligence to ascertain the insurance needs of a client or a principal.

f. Misstatements made under oath or upon an application for membership on an exchange.

g. Failure to testify or produce documents when requested by the office.

h. Willful violation of any law of this state.

i. Failure of an officer or principal to testify under oath concerning a member, associate broker, or other person's affairs as they relate to the operation of an exchange.

j. Violation of the constitution and bylaws of the exchange.

32. Penalties for participating in prohibited conduct.—

a. The office may order the suspension of further transaction of business on the exchange of any member or associate broker found to have engaged in prohibited conduct. In addition, any member or associate broker found to have engaged in prohibited conduct may be subject to reprimand, censure, and/or a fine not exceeding $25,000 imposed by the office.

b. Any member which has an affiliated person who is found to have engaged in prohibited conduct shall be subject to involuntary withdrawal or in addition thereto may be subject to suspension, reprimand, censure, and/or a fine not exceeding $25,000.

33. Reduction of penalties.—Any suspension, reprimand, censure, or fine may be remitted or reduced by the office on such terms and conditions as are deemed fair and equitable.

34. Other offenses.—Any member or associate broker that is suspended shall be deprived, during the period of suspension, of all rights and privileges of a member or of an associate broker and may be proceeded against by the office for any offense committed either before or after the date of suspension.

35. Reinstatement.—Any member or associate broker that is suspended may be reinstated at any time on such terms and conditions as the office may specify.

36. Remittance of fines.—Fines imposed under this section shall be remitted to the office and shall be paid into the Insurance Regulatory Trust Fund.

37. Failure to pay fines.—When a member or associate broker has failed to pay a fine for 15 days after it becomes payable, such member or associate broker shall be suspended, unless the office has granted an extension of time to pay such fine.

38. Changes in ownership or assets.—In the event of a major change in the ownership or a major change in the assets of an underwriting member, the underwriting member shall report such change in writing to the office within 30 days of the effective date thereof. The report shall set forth the details of the change. Any change in ownership or assets of more than 5 percent shall be considered a major change.

39. Retaliation.—

a. When by or pursuant to the laws of any other state or foreign country any taxes, licenses, or other fees, in the aggregate, and any fines, penalties, deposit requirements, or

other material obligations, prohibitions, or restrictions are or would be imposed upon an exchange or upon the agents or representatives of such exchange which are in excess of such taxes, licenses, and other fees, in the aggregate, or which are in excess of such fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar exchanges or upon the agents or representatives of such exchanges of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the office upon the exchanges, or upon the agents or representatives of such exchanges, of such other state or country doing business or seeking to do business in this state.

b. Any tax, license, or other obligation imposed by any city, county, or other political subdivision or agency of a state, jurisdiction, or foreign country on an exchange, or on the agents or representatives on an exchange, shall be deemed to be imposed by such state, jurisdiction, or foreign country within the meaning of sub-subparagraph a.

40. Agents.—

a. Agents as defined in ss. 626.015 and 626.914 who are broker members or associate broker members of an exchange shall be allowed only to place on an exchange the same kind or kinds of business that the agent is licensed to place pursuant to Florida law. Direct Florida business as defined in s. 626.916 or

s. 626.917 shall be written through a broker member who is a surplus lines agent as defined in s. 626.914. The activities of each broker member or associate broker with regard to an exchange shall be subject to all applicable provisions of the insurance laws of this state, and all such activities shall constitute transactions under his or her license as an insurance agent for purposes of the Florida insurance law.

b. Premium payments and other requirements.—If an underwriting member has assumed the risk as to a surplus lines coverage and if the premium therefor has been received by the surplus lines agent who placed such insurance, then in all questions thereafter arising under the coverage as between the underwriting member and the insured, the underwriting member shall be deemed to have received the premium due to it for such coverage; and the underwriting member shall be liable to the insured as to losses covered by such insurance, and for unearned premiums which may become payable to the insured upon cancellation of such insurance, whether or not in fact the surplus lines agent is indebted to the underwriting member with respect to such insurance or for any other cause.

41. Improperly issued contracts, riders, and endorsements.—

a. Any insurance policy, rider, or endorsement issued by an underwriting member and otherwise valid which contains any condition or provision not in compliance with the requirements of this section shall not be thereby rendered invalid, except as provided in s. 627.415, but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy, rider, or endorsement been in full compliance with this section. In the event an underwriting

member issues or delivers any policy for an amount which exceeds any limitations otherwise provided in this section, the underwriting member shall be liable to the insured or his or her beneficiary for the full amount stated in the policy in addition to any other penalties that may be imposed.

b. Any insurance contract delivered or issued for delivery in this state governing a subject or subjects of insurance resident, located, or to be performed in this state which, pursuant to the provisions of this section, the underwriting member may not lawfully insure under such a contract shall be cancelable at any time by the underwriting member, any provision of the contract to the contrary notwithstanding; and the underwriting member shall promptly cancel the contract in accordance with the request of the office therefor. No such illegality or cancellation shall be deemed to relieve the underwriting syndicate of any liability incurred by it under the contract while in force or to prohibit the underwriting syndicate from retaining the pro rata earned premium thereon. This provision does not relieve the underwriting syndicate from any penalty otherwise incurred by the underwriting syndicate.

42. Satisfaction of judgments.—

a. Every judgment or decree for the recovery of money heretofore or hereafter entered in any court of competent jurisdiction against any underwriting member shall be fully satisfied within 60 days from and after the entry thereof or, in the case of an appeal from such judgment or decree, within 60 days from and after the affirmance of the judgment or decree by the appellate court.

b. If the judgment or decree is not satisfied as required

852 under sub-subparagraph a., and proof of such failure to satisfy
853 is made by filing with the office a certified transcript of the
854 docket of the judgment or the decree together with a certificate
855 by the clerk of the court wherein the judgment or decree remains
856 unsatisfied, in whole or in part, after the time provided in
857 sub-subparagraph a., the office shall forthwith prohibit the
858 underwriting member from transacting business. The office shall
859 not permit such underwriting member to write any new business
860 until the judgment or decree is wholly paid and satisfied and
861 proof thereof is filed with the office under the official
862 certificate of the clerk of the court wherein the judgment was
863 recovered, showing that the judgment or decree is satisfied of
864 record, and until the expenses and fees incurred in the case are
865 also paid by the underwriting syndicate.
866 43. Tender and exchange offers.—No person shall conclude a
867 tender offer or an exchange offer or otherwise acquire 5 percent
868 or more of the outstanding voting securities of an underwriting
869 member or controlling company or purchase 5 percent or more of
870 the ownership of an underwriting member or controlling company
871 unless such person has filed with, and obtained the approval of,
872 the office and sent to such underwriting member a statement
873 setting forth:
874 a. The identity of, and background information on, each
875 person by whom, or on whose behalf, the acquisition is to be
876 made; and, if the acquisition is to be made by or on behalf of a
877 corporation, association, or trust, the identity of and
878 background information on each director, officer, trustee, or
879 other natural person performing duties similar to those of a
880 director, officer, or trustee for the corporation, association,

or trust.

b. The source and amount of the funds or other consideration used, or to be used, in making the acquisition.

c. Any plans or proposals which such person may have to liquidate such member, to sell its assets, or to merge or consolidate it.

d. The percentage of ownership which such person proposes to acquire and the terms of the offer or exchange, as the case may be.

e. Information as to any contracts, arrangements, or understandings with any party with respect to any securities of such member or controlling company, including, but not limited to, information relating to the transfer of any securities, option arrangements, or puts or calls or the giving or withholding of proxies, naming the party with whom such contract, arrangements, or understandings have been entered and giving the details thereof.

f. The office may disapprove any acquisition subject to the provisions of this subparagraph by any person or any affiliated person of such person who:

(I) Willfully violates this subparagraph;

(II) In violation of an order of the office issued pursuant to sub-subparagraph j., fails to divest himself or herself of any stock obtained in violation of this subparagraph, or fails to divest himself or herself of any direct or indirect control of such stock, within 25 days after such order; or

(III) In violation of an order issued by the office pursuant to sub-subparagraph j., acquires additional stock of the underwriting member or controlling company, or direct or


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indirect control of such stock, without complying with this subparagraph.

g. The person or persons filing the statement required by this subparagraph have the burden of proof. The office shall approve any such acquisition if it finds, on the basis of the record made during any proceeding or on the basis of the filed statement if no proceeding is conducted, that:

(I) Upon completion of the acquisition, the underwriting member will be able to satisfy the requirements for the approval to write the line or lines of insurance for which it is presently approved;

(II) The financial condition of the acquiring person or persons will not jeopardize the financial stability of the underwriting member or prejudice the interests of its policyholders or the public;

(III) Any plan or proposal which the acquiring person has, or acquiring persons have, made:

(A) To liquidate the insurer, sell its assets, or merge or consolidate it with any person, or to make any other major change in its business or corporate structure or management; or

(B) To liquidate any controlling company, sell its assets, or merge or consolidate it with any person, or to make any major change in its business or corporate structure or management which would have an effect upon the underwriting member

is fair and free of prejudice to the policyholders of the underwriting member or to the public;

(IV) The competence, experience, and integrity of those persons who will control directly or indirectly the operation of

the underwriting member indicate that the acquisition is in the best interest of the policyholders of the underwriting member and in the public interest;

(V) The natural persons for whom background information is required to be furnished pursuant to this subparagraph have such backgrounds as to indicate that it is in the best interests of the policyholders of the underwriting member, and in the public interest, to permit such persons to exercise control over such underwriting member;

(VI) The officers and directors to be employed after the acquisition have sufficient insurance experience and ability to assure reasonable promise of successful operation;

(VII) The management of the underwriting member after the acquisition will be competent and trustworthy and will possess sufficient managerial experience so as to make the proposed operation of the underwriting member not hazardous to the insurance-buying public;

(VIII) The management of the underwriting member after the acquisition will not include any person who has directly or indirectly through ownership, control, reinsurance transactions, or other insurance or business relations unlawfully manipulated the assets, accounts, finances, or books of any insurer or underwriting member or otherwise acted in bad faith with respect thereto;

(IX) The acquisition is not likely to be hazardous or prejudicial to the underwriting member’s policyholders or the public; and

(X) The effect of the acquisition of control would not substantially lessen competition in insurance in this state or

would not tend to create a monopoly therein.

h. No vote by the stockholder of record, or by any other person, of any security acquired in contravention of the provisions of this subparagraph is valid. Any acquisition of any security contrary to the provisions of this subparagraph is void. Upon the petition of the underwriting member or controlling company, the circuit court for the county in which the principal office of such underwriting member is located may, without limiting the generality of its authority, order the issuance or entry of an injunction or other order to enforce the provisions of this subparagraph. There shall be a private right of action in favor of the underwriting member or controlling company to enforce the provisions of this subparagraph. No demand upon the office that it perform its functions shall be required as a prerequisite to any suit by the underwriting member or controlling company against any other person, and in no case shall the office be deemed a necessary party to any action by such underwriting member or controlling company to enforce the provisions of this subparagraph. Any person who makes or proposes an acquisition requiring the filing of a statement pursuant to this subparagraph, or who files such a statement, shall be deemed to have thereby designated the Chief Financial Officer as such person’s agent for service of process under this subparagraph and shall thereby be deemed to have submitted himself or herself to the administrative jurisdiction of the office and to the jurisdiction of the circuit court.

i. Any approval by the office under this subparagraph does not constitute a recommendation by the office for an acquisition, tender offer, or exchange offer. It is unlawful for

a person to represent that the office's approval constitutes a recommendation. A person who violates the provisions of this sub-subparagraph is guilty of a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The statute-of-limitations period for the prosecution of an offense committed under this sub-subparagraph is 5 years.

j. Upon notification to the office by the underwriting member or a controlling company that any person or any affiliated person of such person has acquired 5 percent or more of the outstanding voting securities of the underwriting member or controlling company without complying with the provisions of this subparagraph, the office shall order that the person and any affiliated person of such person cease acquisition of any further securities of the underwriting member or controlling company; however, the person or any affiliated person of such person may request a proceeding, which proceeding shall be convened within 7 days after the rendering of the order for the sole purpose of determining whether the person, individually or in connection with any affiliated person of such person, has acquired 5 percent or more of the outstanding voting securities of an underwriting member or controlling company. Upon the failure of the person or affiliated person to request a hearing within 7 days, or upon a determination at a hearing convened pursuant to this sub-subparagraph that the person or affiliated person has acquired voting securities of an underwriting member or controlling company in violation of this subparagraph, the office may order the person and affiliated person to divest themselves of any voting securities so acquired.

k.(I) The office shall, if necessary to protect the public

interest, suspend or revoke the certificate of authority of any underwriting member or controlling company:

(A) The control of which is acquired in violation of this subparagraph;

(B) That is controlled, directly or indirectly, by any person or any affiliated person of such person who, in violation of this subparagraph, has obtained control of an underwriting member or controlling company; or

(C) That is controlled, directly or indirectly, by any person who, directly or indirectly, controls any other person who, in violation of this subparagraph, acquires control of an underwriting member or controlling company.

(II) If any underwriting member is subject to suspension or revocation pursuant to sub-sub-subparagraph (I), the underwriting member shall be deemed to be in such condition, or to be using or to have been subject to such methods or practices in the conduct of its business, as to render its further transaction of insurance presently or prospectively hazardous to its policyholders, creditors, or stockholders or to the public.

l.(I) For the purpose of this sub-sub-subparagraph, the term "affiliated person" of another person means:

(A) The spouse of such other person;

(B) The parents of such other person and their lineal descendants and the parents of such other person's spouse and their lineal descendants;

(C) Any person who directly or indirectly owns or controls, or holds with power to vote, 5 percent or more of the outstanding voting securities of such other person;

(D) Any person 5 percent or more of the outstanding voting

securities of which are directly or indirectly owned or controlled, or held with power to vote, by such other person;

(E) Any person or group of persons who directly or indirectly control, are controlled by, or are under common control with such other person; or any officer, director, partner, copartner, or employee of such other person;

(F) If such other person is an investment company, any investment adviser of such company or any member of an advisory board of such company;

(G) If such other person is an unincorporated investment company not having a board of directors, the depositor of such company; or

(H) Any person who has entered into an agreement, written or unwritten, to act in concert with such other person in acquiring or limiting the disposition of securities of an underwriting member or controlling company.

(II) For the purposes of this section, the term "controlling company" means any corporation, trust, or association owning, directly or indirectly, 25 percent or more of the voting securities of one or more underwriting members.

m. The commission may adopt, amend, or repeal rules that are necessary to implement the provisions of this subparagraph, pursuant to chapter 120.

44. Background information.—The information as to the background and identity of each person about whom information is required to be furnished pursuant to sub-subparagraph 43.a. shall include, but shall not be limited to:

a. Such person's occupations, positions of employment, and offices held during the past 10 years.

b. The principal business and address of any business, corporation, or other organization in which each such office was held or in which such occupation or position of employment was carried on.

c. Whether, at any time during such 10-year period, such person was convicted of any crime other than a traffic violation.

d. Whether, during such 10-year period, such person has been the subject of any proceeding for the revocation of any license and, if so, the nature of such proceeding and the disposition thereof.

e. Whether, during such 10-year period, such person has been the subject of any proceeding under the federal Bankruptcy Act or whether, during such 10-year period, any corporation, partnership, firm, trust, or association in which such person was a director, officer, trustee, partner, or other official has been subject to any such proceeding, either during the time in which such person was a director, officer, trustee, partner, or other official, or within 12 months thereafter.

f. Whether, during such 10-year period, such person has been enjoined, either temporarily or permanently, by a court of competent jurisdiction from violating any federal or state law regulating the business of insurance, securities, or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities, or banking, together with details of any such event.

45. Security fund.—All underwriting members shall be members of the security fund of any exchange.

46. Underwriting member defined.—Whenever the term

"underwriting member" is used in this subsection, it shall be construed to mean "underwriting syndicate."

47. Offsets.—Any action, requirement, or constraint imposed by the office shall reduce or offset similar actions, requirements, or constraints of any exchange.

48. Restriction on member ownership.—

a. Investments existing prior to July 2, 1987.—The investment in any member by brokers, agents, and intermediaries transacting business on the exchange, and the investment in any such broker, agent, or intermediary by any member, directly or indirectly, shall in each case be limited in the aggregate to less than 20 percent of the total investment in such member, broker, agent, or intermediary, as the case may be. After December 31, 1987, the aggregate percent of the total investment in such member by any broker, agent, or intermediary and the aggregate percent of the total investment in any such broker, agent, or intermediary by any member, directly or indirectly, shall not exceed 15 percent. After June 30, 1988, such aggregate percent shall not exceed 10 percent and after December 31, 1988, such aggregate percent shall not exceed 5 percent.

b. Investments arising on or after July 2, 1987.—The investment in any underwriting member by brokers, agents, or intermediaries transacting business on the exchange, and the investment in any such broker, agent, or intermediary by any underwriting member, directly or indirectly, shall in each case be limited in the aggregate to less than 5 percent of the total investment in such underwriting member, broker, agent, or intermediary.

49. "Underwriting manager" defined.—"Underwriting manager"

as used in this subparagraph includes any person, partnership, corporation, or organization providing any of the following services to underwriting members of the exchange:

a. Office management and allied services, including correspondence and secretarial services.

b. Accounting services, including bookkeeping and financial report preparation.

c. Investment and banking consultations and services.

d. Underwriting functions and services including the acceptance, rejection, placement, and marketing of risk.

50. Prohibition of underwriting manager investment.—Any direct or indirect investment in any underwriting manager by a broker member or any affiliated person of a broker member or any direct or indirect investment in a broker member by an underwriting manager or any affiliated person of an underwriting manager is prohibited. "Affiliated person" for purposes of this subparagraph is defined in subparagraph 43.

51. An underwriting member may not accept reinsurance on an assumed basis from an affiliate or a controlling company, nor may a broker member or management company place reinsurance from an affiliate or controlling company of theirs with an underwriting member. "Affiliate and controlling company" for purposes of this subparagraph is defined in subparagraph 43.

52. Premium defined.—"Premium" is the consideration for insurance, by whatever name called. Any "assessment" or any "membership," "policy," "survey," "inspection," "service" fee or charge or similar fee or charge in consideration for an insurance contract is deemed part of the premium.

53. Rules.—The commission shall adopt rules necessary for

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or as an aid to the effectuation of any provision of this section.

Section 15. Subsection (6) of section 634.121, Florida Statutes, is amended to read:

634.121 Forms, required procedures, provisions; delivery and definitions.—

(6)(a) Each service agreement, which includes a copy of the application form, must be mailed, delivered, or otherwise provided electronically ~~transmitted~~ to the agreement holder as provided in s. 627.421. As used in s. 627.421, the term:

1. "Insurance policies and endorsements," "policy and endorsement," "policy," or "policy form and endorsement form" includes a motor vehicle service agreement and related endorsement forms.

2. "Insured" includes a motor vehicle service agreement holder.

3. "Insurer" includes a motor vehicle service agreement company.

(b) Section 627.421(4) applies if the motor vehicle service agreement company elects to post motor vehicle service agreements on its Internet website in lieu of mailing or delivery to agreement holders ~~within 45 days after the date of purchase~~. ~~Electronic transmission of a service agreement constitutes delivery to the agreement holder~~. ~~The electronic transmission must notify the agreement holder of his or her right to receive the service agreement via United States mail rather than electronic transmission. If the agreement holder communicates to the service agreement company electronically or in writing that he or she does not agree to receipt by~~


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~~electronic transmission, a paper copy of the service agreement shall be provided to the agreement holder.~~

Section 16. Section 641.3107, Florida Statutes, is amended to read:

641.3107 Delivery of contract and certain documents; definitions.—

(1) ~~Unless delivered upon execution or issuance,~~ A health maintenance contract, certificate of coverage, endorsements and riders, or member handbook must ~~shall~~ be mailed, ~~or~~ delivered, or otherwise provided to the subscriber or, in the case of a group health maintenance contract, to the employer or other person who will hold the contract on behalf of the subscriber group, as provided in s. 627.421.

(2) As used in s. 627.421, the term:

(a) "Insurance policies and endorsements," "policy and endorsement," "policy," or "policy form and endorsement form" includes the health maintenance contract, endorsement and riders, certificate of coverage, or member handbook.

(b) "Insured" includes a subscriber or, in the case of a group health maintenance contract, to the employer or other person who will hold the contract on behalf of the subscriber group.

(c) "Insurer" includes a health maintenance organization.

(3) Section 627.421(4) applies if the health maintenance organization elects to post health maintenance contracts on its Internet website in lieu of mailing or delivery to subscribers or the person who will hold the contract on behalf of a subscriber group ~~within 10 working days from approval of the enrollment form by the health maintenance organization or by the~~

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~~effective date of coverage, whichever occurs first~~. ~~However, if the employer or other person who will hold the contract on behalf of the subscriber group requires retroactive enrollment of a subscriber, the organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving notice from the employer of the retroactive enrollment.~~ This section does not apply to the delivery of those contracts specified in s. 641.31(13).

Section 17. This act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to insurance; amending s. 625.151, F.S.; providing that certain securities valuation limitations do not apply to certain stock of certain foreign insurers' subsidiary corporations or related entities; amending s. 625.325, F.S.; providing that certain provisions relating to insurer investments in subsidiaries and related corporations do not apply to foreign insurers under certain circumstances; amending s. 626.221, F.S.; providing an exception from an examination requirement for an all-lines adjuster license applicant with a specified designation; amending s. 626.914, F.S.; revising the definition of the term "diligent effort" to decrease the dwelling replacement cost threshold of a residential structure

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to which a different diligent effort requirement under the Surplus Lines Law applies; repealing s. 626.918(2)(a), F.S., relating to a certain condition before an unauthorized insurer may be or become an eligible surplus lines insurer; amending s. 626.932, F.S.; reducing the tax on surplus lines insurance; deleting a limitation on the tax rate for certain surplus lines policies; amending s. 626.9651, F.S.; revising federal standards applicable to Department of Financial Services and Financial Services Commission rules governing the use of consumer nonpublic personal financial and health information; amending s. 627.416, F.S.; authorizing insurers to issue policies that are not executed by certain authorized persons; amending s. 627.43141, F.S.; specifying that a written notice of a change in policy terms must summarize the change; amending s. 627.7015, F.S.; authorizing a third party, as assignee of the policy benefits, to request mediation for disputed property insurance claims; providing that insurers are not required to participate in such mediations; making technical changes; amending s. 627.728, F.S.; adding certain proofs of mailing that an insurer may use to provide certain notices relating to cancellation and nonrenewals of policies to certain insureds; amending s. 628.4615, F.S.; revising the definition of the term “specialty insurer” to include viatical settlement providers; providing that a person may rebut a presumption of control by filing a specified


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disclaimer with the Office of Insurance Regulation; providing an alternative to a form prescribed by the commission; providing construction; conforming cross-references; amending s. 628.8015, F.S.; deleting a condition that certain filings and documents relating to insurer own-risk and solvency assessments and corporate governance annual disclosures must be obtained from the office to be inadmissible in evidence in private civil actions; amending s. 629.401, F.S.; revising unearned premium reserve requirements for insurance exchanges regulated by the office; defining the term "net written premiums"; amending s. 634.121, F.S.; revising requirements and procedures for the delivery of motor vehicle service agreements and certain forms by motor vehicle service agreement companies to agreement holders; defining terms; specifying requirements if a motor vehicle service agreement company elects to post service agreements on its website in lieu of mailing or delivering to agreement holders; amending s. 641.3107, F.S.; revising requirements and procedures for the delivery of health maintenance contracts and certain documents by health maintenance organizations to subscribers; defining terms; specifying requirements if a health maintenance organization elects to post health maintenance contracts on its website in lieu of mailing or delivering to subscribers or certain persons; providing an effective date.

755264

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2018	.	
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	.	
	.	

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

Senate Amendment to Amendment (449152) (with title amendment)

Delete lines 52 - 54
and insert:
Professional (CACP) from WebCE, Inc., ~~or~~ Universal Claims Certification (UCC) from Claims and Litigation Management Alliance (CLM), or any similar designation from a similar entity whose curriculum has been approved by the

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========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 1252 - 1254
and insert:
s. 626.221, F.S.; revising professional designations that exempt all-lines adjuster license applicants from an examination requirement;

584058

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/06/2018	.	
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	.	

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

Senate Amendment to Amendment (449152) (with title amendment)

Between lines 1236 and 1237
insert:

Section 17. Subsection (1) of section 627.756, Florida Statutes, is amended to read:

627.756 Bonds for construction contracts; attorney fees in case of suit.—

(1) Section 627.428 applies to suits brought by owners,

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contractors, subcontractors, laborers, and materialmen against a surety insurer under payment or performance bonds written by the insurer under the laws of this state to indemnify against pecuniary loss by breach of a building or construction contract. Owners, contractors, subcontractors, laborers, and materialmen are ~~shall be~~ deemed to be insureds or beneficiaries for the purposes of this section.

Section 18. For the purpose of incorporating the amendment made by this act to section 627.756, Florida Statutes, in a reference thereto, section 627.428, Florida Statutes, is reenacted to read:

627.428 Attorney's fee.—

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

(2) As to suits based on claims arising under life insurance policies or annuity contracts, no such attorney's fee shall be allowed if such suit was commenced prior to expiration of 60 days after proof of the claim was duly filed with the insurer.

(3) When so awarded, compensation or fees of the attorney shall be included in the judgment or decree rendered in the case.

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Section 19. The amendment made by this act to s. 627.756, Florida Statutes, applies only to payment or performance bonds issued on or after October 1, 2018.

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

And the title is amended as follows:

Delete line 1314

and insert:

persons; amending s. 627.756, F.S.; providing that certain attorney fee provisions apply to suits brought by contractors against surety insurers under payment or performance bonds for building or construction contracts; providing that contractors are deemed to be insureds or beneficiaries for the purposes of such provisions; reenacting s. 627.428, F.S., relating to attorney fees, to incorporate the amendment made to s. 627.756, F.S., in a reference thereto; providing applicability; providing an effective date.

909708

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2018	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (449152) (with title amendment)

Between lines 1236 and 1237
insert:

Section 17. Subsection (1) of section 627.756, Florida Statutes, is amended to read:

627.756 Bonds for construction contracts; attorney fees in case of suit.—

(1) Section 627.428 applies to suits brought by owners,

909708

contractors, subcontractors, laborers, and materialmen against a surety insurer under payment or performance bonds written by the insurer under the laws of this state to indemnify against pecuniary loss by breach of a building or construction contract. Owners, contractors, subcontractors, laborers, and materialmen are ~~shall be~~ deemed to be insureds or beneficiaries for the purposes of this section.

Section 18. The amendment made by this act to s. 627.756, Florida Statutes, applies only to payment or performance bonds issued on or after October 1, 2018.

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

And the title is amended as follows:

Delete line 1314

and insert:

persons; amending s. 627.756, F.S.; providing that certain attorney fee provisions apply to suits brought by contractors against surety insurers under payment or performance bonds for building or construction contracts; providing that contractors are deemed to be insureds or beneficiaries for the purposes of such provisions; providing applicability; providing an effective date.

By Senator Brandes

24-00599C-18 2018784__

A bill to be entitled

An act relating to insurance; amending s. 624.307, F.S.; specifying certain persons are not consumers for purposes of calculating complaint ratios; amending s. 625.151, F.S.; providing an exception from valuation rules for stocks in subsidiaries for certain foreign insurers under certain conditions; amending s. 625.325, F.S.; exempting foreign insurers from investment requirements relating to subsidiaries and corporations under certain conditions; amending s. 626.914, F.S.; revising the definition of the term "diligent effort" to decrease the replacement cost threshold for a residential structure for purposes of proving rejection of coverage by authorized insurers; amending s. 626.918, F.S.; increasing the amount of capital and surplus required for an insurer to waive a requirement to be an eligible surplus lines insurer; amending s. 626.932, F.S.; deleting a provision relating to a surplus lines tax threshold; amending s. 626.9651, F.S.; revising requirements for rules adopted by the Department of Financial Services and the Financial Services Commission relating to the privacy of certain consumer information; amending s. 626.9891, F.S.; authorizing, rather than requiring, an insurer to report certain data; amending s. 627.4136, F.S.; providing applicability; amending s. 627.7015, F.S.; authorizing insurers to participate in mediations requested by third parties; revising terminology; revising the definition of the term

24-00599C-18 2018784__

"claim" to specify that any material issue of fact must relate to a loss arising from a declared state of emergency; amending s. 627.728, F.S.; providing that an Intelligent Mail barcode or a similar United States Postal Service tracking method is sufficient proof of notice for certain motor vehicle insurance notices; amending s. 627.748, F.S.; revising circumstances in which insurers may exclude coverage for owners or operators of transportation network company vehicles; amending s. 628.8015, F.S.; revising the type of documents that are confidential; amending s. 636.044, F.S.; providing an exemption from licensing requirements for a person who sells certain prepaid limited health service contracts; providing an effective date.

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

Section 1. Paragraph (e) is added to subsection (10) of section 624.307, Florida Statutes, to read:

624.307 General powers; duties.—

(10)

(e) For purposes of this subsection, a third-party vendor, as an assignee of policy benefits, is not a consumer. Inquiries or complaints from a third-party vendor, as an assignee of policy benefits, may not be used when calculating a complaint ratio pursuant to s. 624.313.

Section 2. Paragraph (c) is added to subsection (3) of section 625.151, Florida Statutes, to read:

625.151 Valuation of other securities.—

(3) Stock of a subsidiary corporation of an insurer may ~~shall~~ not be valued at an amount in excess of the net value thereof as based upon those assets only of the subsidiary which would be eligible under part II for investment of the funds of the insurer directly.

(c) This subsection does not apply to stock of a subsidiary corporation or related entities of a foreign insurer that is permissible under the laws of its state of domicile if the state of domicile is a member of the National Association of Insurance Commissioners.

Section 3. Subsection (7) is added to section 625.325, Florida Statutes, to read:

625.325 Investments in subsidiaries and related corporations.—

(7) APPLICABILITY.-This section does not apply to a foreign insurer's investments in its subsidiaries or related corporations if:

(a) The foreign insurer is domiciled in a state that is a member of the National Association of Insurance Commissioners (NAIC).

(b) Such investments in the foreign insurer's subsidiaries or related corporations are:

1. Permitted under the laws of the foreign insurer's state of domicile.

2.a. Assigned a rating of 1, 2, or 3 by the NAIC's Securities Valuation Office (SVO); or

b. Qualify for the NAIC's filing exemption rule and assigned a rating by a nationally recognized statistical rating

organization that would be equivalent to a rating of 1, 2, or 3 by the SVO.

Section 4. Subsection (4) of section 626.914, Florida Statutes, is amended to read:

626.914 Definitions.—As used in this Surplus Lines Law, the term:

(4) "Diligent effort" means seeking coverage from and having been rejected by at least three authorized insurers currently writing this type of coverage and documenting these rejections. However, if the residential structure has a dwelling replacement cost of $750,000 ~~$1 million~~ or more, the term means seeking coverage from and having been rejected by at least one authorized insurer currently writing this type of coverage and documenting this rejection.

Section 5. Paragraph (b) of subsection (2) of section 626.918, Florida Statutes, is amended to read:

626.918 Eligible surplus lines insurers.—

(2) An unauthorized insurer may not be or become an eligible surplus lines insurer unless made eligible by the office in accordance with the following conditions:

(b) The insurer must be currently an authorized insurer in the state or country of its domicile as to the kind or kinds of insurance proposed to be so placed and must have been such an insurer for not less than the 3 years next preceding or must be the wholly owned subsidiary of such authorized insurer or must be the wholly owned subsidiary of an already eligible surplus lines insurer as to the kind or kinds of insurance proposed for a period of not less than the 3 years next preceding. However, the office may waive the 3-year requirement if the insurer

provides a product or service not readily available to the consumers of this state or has operated successfully for a period of at least 1 year next preceding and has capital and surplus of not less than $30 ~~$25~~ million.

Section 6. Subsection (3) of section 626.932, Florida Statutes, is amended to read:

626.932 Surplus lines tax.—

(3) If a surplus lines policy covers risks or exposures only partially in this state and the state is the home state as defined in the federal Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), the tax payable must ~~shall~~ be computed on the gross premium. ~~The tax must not exceed the tax rate where the risk or exposure is located.~~

Section 7. Section 626.9651, Florida Statutes, is amended to read:

626.9651 Privacy.—The department and commission must ~~shall~~ each adopt rules consistent with other provisions of the Florida Insurance Code to govern the use of a consumer's nonpublic personal financial and health information. These rules must be based on, consistent with, and not more restrictive than the Privacy of Consumer Financial and Health Information Regulation, adopted September 26, 2000, by the National Association of Insurance Commissioners; however, the rules must permit the use and disclosure of nonpublic personal health information for scientific, medical, or public policy research, in accordance with federal law. In addition, these rules must be consistent with, and not more restrictive than, the standards contained in Title V of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102, as amended in Title LXXV of the Fixing America's Surface

Transportation (FAST) Act, Pub. L. No. 114-94. If the office determines that a health insurer or health maintenance organization is in compliance with, or is actively undertaking compliance with, the consumer privacy protection rules adopted by the United States Department of Health and Human Services, in conformance with the Health Insurance Portability and Affordability Act, that health insurer or health maintenance organization is in compliance with this section.

Section 8. Subsection (5) of section 626.9891, Florida Statutes, is amended to read:

626.9891 Insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance.—

(5) Each insurer is required to report data related to fraud for each identified line of business written by the insurer during the prior calendar year. The data must ~~shall~~ be reported to the department by March 1, 2019, and annually thereafter, and may ~~must~~ include~~, at a minimum~~:

(a) The number of policies in effect;

(b) The amount of premiums written for policies;

(c) The number of claims received;

(d) The number of claims referred to the anti-fraud investigative unit;

(e) The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;

(f) The number of claims investigated or accepted by the anti-fraud investigative unit;

(g) The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;

(h) The number of cases referred to the Division of Investigative and Forensic Services;

(i) The number of cases referred to other law enforcement agencies;

(j) The number of cases referred to other entities; and

(k) The estimated dollar amount or range of damages on cases referred to the Division of Investigative and Forensic Services or other agencies.

Section 9. Subsection (5) is added to section 627.4136, Florida Statutes, to read:

627.4136 Nonjoinder of insurers.—

(5) This section applies to surplus lines liability insurers.

Section 10. Subsections (1), (3), (6), and (9) of section 627.7015, Florida Statutes, are amended to read:

627.7015 Alternative procedure for resolution of disputed property insurance claims.—

(1) This section sets forth a nonadversarial alternative dispute resolution procedure for a mediated claim resolution conference prompted by the need for effective, fair, and timely handling of property insurance claims. There is a particular need for an informal, nonthreatening forum for helping parties who elect this procedure to resolve their claims disputes because most homeowner and commercial residential insurance policies obligate policyholders to participate in a potentially expensive and time-consuming adversarial appraisal process before litigation. The procedure set forth in this section is designed to bring the parties together for a mediated claims settlement conference without any of the trappings or drawbacks

of an adversarial process. Before resorting to these procedures, policyholders and insurers are encouraged to resolve claims as quickly and fairly as possible. This section is available with respect to claims under personal lines and commercial residential policies before commencing the appraisal process, or before commencing litigation. Mediation may be requested only by the policyholder, as a first-party claimant, or the insurer. An insurer may, but is not required to, participate in mediation requested by a third party, as an assignee of policy benefits. If requested by the policyholder, participation by legal counsel is permitted. Mediation under this section is also available to litigants referred to the department by a county court or circuit court. This section does not apply to commercial coverages, to private passenger motor vehicle insurance coverages, or to disputes relating to liability coverages in policies of property insurance.

(3) The costs of mediation must ~~shall~~ be reasonable, and the insurer must ~~shall~~ bear all of the cost of conducting mediation conferences, except as otherwise provided in this section. If a policyholder ~~an insured~~ fails to appear at the conference, the conference must ~~shall~~ be rescheduled upon the policyholder's ~~insured's~~ payment of the costs of a rescheduled conference. If the insurer fails to appear at the conference, the insurer must ~~shall~~ pay the policyholder's ~~insured's~~ actual cash expenses incurred in attending the conference if the insurer's failure to attend was not due to a good cause acceptable to the department. An insurer will be deemed to have failed to appear if the insurer's representative lacks authority to settle the full value of the claim. The insurer shall incur

an additional fee for a rescheduled conference necessitated by the insurer's failure to appear at a scheduled conference. The fees assessed by the administrator must ~~shall~~ include a charge necessary to defray the expenses of the department related to its duties under this section and must ~~shall~~ be deposited in the Insurance Regulatory Trust Fund.

(6) Mediation is nonbinding; however, if a written settlement is reached, the policyholder ~~insured~~ has 3 business days within which the policyholder ~~insured~~ may rescind the settlement unless the policyholder ~~insured~~ has cashed or deposited any check or draft disbursed to the policyholder ~~insured~~ for the disputed matters as a result of the conference. If a settlement agreement is reached and is not rescinded, it is ~~shall be~~ binding and acts ~~act~~ as a release of all specific claims that were presented in that mediation conference.

(9) For purposes of this section, the term "claim" refers to any dispute between an insurer and a policyholder relating to a material issue of fact other than a dispute:

(a) With respect to which the insurer has a reasonable basis to suspect fraud;

(b) When ~~Where~~, based on agreed-upon facts as to the cause of loss, there is no coverage under the policy;

(c) With respect to which the insurer has a reasonable basis to believe that the policyholder has intentionally made a material misrepresentation of fact which is relevant to the claim, and the entire request for payment of a loss has been denied on the basis of the material misrepresentation;

(d) With respect to which the amount in controversy is less than $500, unless the parties agree to mediate a dispute

involving a lesser amount; or

(e) With respect to a windstorm or hurricane loss that does not comply with s. 627.70132.

Section 11. Subsection (5) of section 627.728, Florida Statutes, is amended to read:

627.728 Cancellations; nonrenewals.—

(5) United States postal proof of mailing, ~~or~~ certified or registered mailing, or other mailing using the Intelligent Mail barcode or other similar tracking method used or approved by the United States Postal Service of notice of cancellation, of intention not to renew, or of reasons for cancellation, or of the intention of the insurer to issue a policy by an insurer under the same ownership or management, to the first-named insured at the address shown in the policy is ~~shall be~~ sufficient proof of notice.

Section 12. Paragraph (b) of subsection (8) of section 627.748, Florida Statutes, is amended to read:

627.748 Transportation network companies.—

(8) TRANSPORTATION NETWORK COMPANY AND INSURER; DISCLOSURE; EXCLUSIONS.—

(b)1. An insurer that provides an automobile liability insurance policy under this part may exclude any and all coverage afforded under the policy issued to an owner or operator of a TNC vehicle ~~while driving that vehicle~~ for any loss or injury that occurs while a TNC driver is logged on to a digital network and driving a motor vehicle, or when ~~while~~ a TNC driver provides a prearranged ride. Exclusions imposed under this subsection are limited to coverage while a TNC driver is logged on to a digital network or while a TNC driver provides a

prearranged ride. This right to exclude all coverage may apply to any coverage included in an automobile insurance policy, including, but not limited to:

a. Liability coverage for bodily injury and property damage;

b. Uninsured and underinsured motorist coverage;

c. Medical payments coverage;

d. Comprehensive physical damage coverage;

e. Collision physical damage coverage; and

f. Personal injury protection.

2. The exclusions described in subparagraph 1. apply notwithstanding any requirement under chapter 324. These exclusions do not affect or diminish coverage otherwise available for permissive drivers or resident relatives under the personal automobile insurance policy of the TNC driver or owner of the TNC vehicle who are not occupying the TNC vehicle at the time of loss. This section does not require that a personal automobile insurance policy provide coverage while the TNC driver is logged on to a digital network, while the TNC driver is engaged in a prearranged ride, or while the TNC driver otherwise uses a vehicle to transport riders for compensation.

3. This section must not be construed to require an insurer to use any particular policy language or reference to this section in order to exclude any and all coverage for any loss or injury that occurs while a TNC driver is logged on to a digital network or while a TNC driver provides a prearranged ride.

4. This section does not preclude an insurer from providing primary or excess coverage for the TNC driver's vehicle by contract or endorsement.

Section 13. Subsection (4) of section 628.8015, Florida Statutes, is amended to read:

628.8015 Own-risk and solvency assessment; corporate governance annual disclosure.—

(4) CONFIDENTIALITY.—The required filings and related documents submitted pursuant to subsections (2) and (3) are privileged such that they may not be produced in response to a subpoena or other discovery directed to the office, and any such filings and related documents~~, if obtained from the office,~~ are not admissible in evidence in any private civil action. However, the department or office may use these filings and related documents in the furtherance of any regulatory or legal action brought against an insurer as part of the official duties of the department or office. A waiver of any applicable claim of privilege in these filings and related documents may not occur because of a disclosure to the office under this section, because of any other provision of the Insurance Code, or because of sharing under s. 624.4212. The office or a person receiving these filings and related documents, while acting under the authority of the office, or with whom such filings and related documents are shared pursuant to s. 624.4212, is not permitted or required to testify in any private civil action concerning any such filings or related documents.

Section 14. Subsection (5) of section 636.044, Florida Statutes, is amended to read:

636.044 Agent licensing.—

(5) A person who sells ~~registered as a seller of travel under s. 559.928 is not required to be licensed under this section in order to sell~~ prepaid limited health service

contracts that only cover the cost of transportation provided by an air ambulance service licensed pursuant to s. 401.251 is not required to be licensed under this section. The prepaid limited health service contract for such coverage is, however, subject to all applicable provisions of this chapter.

Section 15. This act shall take effect upon becoming a law.

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: November 17, 2017

I respectfully request that **Senate Bill #784**, relating to **Insurance**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 24

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

784
Bill Number (if applicable)

Topic Insurance

Amendment Barcode (if applicable)

Name Beth A. Vecchioli (pronounced Vetch-ee-o-lee)

Job Title Sr. Director, Govt. Consulting

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City *State* *Zip*

Phone 850-425-3393

Email bvecchioli@carltonfields.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Privilege Underwriters Reciprocal Exchange

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Feb 6th
Meeting Date

784
Bill Number (if applicable)

Topic For Strike All + Bill

Amendment Barcode (if applicable)

Name Tim Meenan

Job Title

Address 325 W Duval Street
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Tallahassee FL 32302
City *State* *Zip*

Phone 850 425-4000

Email Tim@MeenanLawFirm.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Nationwide

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)

W/D

THE FLORIDA SENATE

APPEARANCE RECORD

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

02/06/2018
Meeting Date

784
Bill Number (if applicable)

584058
Amendment Barcode (if applicable)

Topic Insurance - Construction Bonds

Name Warren Husband

Job Title

Address PO Box 10909
Street

Phone (850) 205-9000

Tallahassee FL 32302
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Associated General Contractors 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:	CS/SB 1106
INTRODUCER:	Banking and Insurance Committee and Senator Bean
SUBJECT:	Genetic Information Used for Insurance
DATE:	February 7, 2018 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1106 prohibits life insurers, including life insurers providing disability insurance, and long-term care insurers from canceling, limiting, or denying coverage or establishing differentials in premium rates, based on genetic information, if there is no diagnosis of a condition related to the genetic information. The bill also prohibits such insurers from requiring or soliciting genetic information or considering a person's decisions or actions relating to genetic testing in any manner for any insurance purpose. Florida currently applies these prohibitions to health insurers.

The bill amends the existing prohibition against health insurers using genetic test results in any manner for any insurance purpose. Under the bill the prohibition applies in the absence of a diagnosis of a condition related to genetic information. The bill applies the revised prohibition to life insurers and long-term care insurers.

The provisions of the bill will apply to policies issued or renewed by life insurers and long-term care insurers on or after January 1, 2019.

II. Present Situation:

Use of Genetic Information for Insurance Purposes – Florida Requirements

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

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

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

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

Federal Laws on the Use of Genetic Information for Insurance Purposes

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

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) amended a number of existing federal laws to prohibit health insurers from using genetic information for underwriting purposes.[3] The act does not apply to life insurance, long-term care insurance or disability insurance.

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[1] Section 627.4301(2)(c), F.S. Other types of insurance that are wholly exempt from the statute are accident-only policies, hospital indemnity or fixed indemnity policies, dental policies, and vision policies.

[2] Section 627.4301(1)(b), F.S., defines health insurer to mean, "an authorized insurer offering health insurance as defined in s. 624.603, F.S., a self-insured plan as defined in s. 624.031, F.S., a multiple-employer welfare arrangement as defined in s. 624.437, F.S., a prepaid limited health service organization as defined in s. 636.003, F.S., a health maintenance organization as defined in s. 641.19, F.S., a prepaid health clinic as defined in s. 641.402, F.S., a fraternal benefit society as defined in s. 632.601, F.S., or any health care arrangement whereby risk is assumed."

[3] Pub. L. No. 110-233, s. 122 Stat. 881-921 (2008). https://www.gpo.gov/fdsys/pkg/PLAW-110publ233/pdf/PLAW-110publ233.pdf (last accessed February 3, 2018).

Title I of GINA provides protections against discrimination by health insurers on the basis of genetic information.[4] GINA prohibits health insurers and health plan administrators from using genetic information to make rating or coverage decisions.[5] These decisions include eligibility for coverage and setting premium or contribution amounts.

GINA generally prohibits health insurers and health plan administrators from requesting or requiring genetic information of an individual or the individual's family members,[6] nor may such information be requested, required or purchased for underwriting purposes.[7] Underwriting purposes include rules for eligibility, determining coverage or benefits, cost-sharing mechanisms, calculating premiums or contribution amounts, rebates, payments in kind, pre-existing condition exclusions, and other activities related to the creation, renewal, or replacement of health insurance or health benefits. Underwriting purposes does not include determining medical appropriateness where an individual seeks a health benefit under a plan, coverage, or policy.[8] Genetic information may be used by an insurer to make a determination regarding the payment of benefits, for example, as the basis of a diagnosis that then would lead to benefits being provided under the insurance policy.

The protections in GINA apply to the individual and group health markets, including employer sponsored plans under the Employee Retirement Income Security Act of 1974 (ERISA).[9] GINA generally expanded many of the genetic information protections in the Health Insurance Portability and Accountability Act of 1996[10] (HIPAA) and applied them to the individual, group and Medicare supplemental marketplaces.[11] The protections enacted in GINA do not apply to Medicare or Medicaid because both programs bar the use of genetic information as a condition of eligibility.[12] GINA also prohibits employment discrimination on the basis of genetic information.[13]

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

Health Insurance Portability and Accountability Act of 1996

HIPAA establishes national standards to ensure the privacy and nondisclosure of personal health information. The rule applies to "covered entities" which means a health plan, health care

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[4] 110th Congress, *Summary: H.R.493 Public Law* (May 21, 2008) (last accessed February 1, 2018).
[5] *See* 29 USC 1182; 42 USC 300gg-1; and 42 USC 300gg-53.
[6] Department of Health and Human Services, *"GINA" The Genetic Information Nondiscrimination Act of 2008: Information for Researchers and Health Care Professionals*, (April 6, 2009). https://www.genome.gov/pages/policyethics/geneticdiscrimination/ginainfodoc.pdf (last accessed February 1, 2018).
[7] *See* 29 USC 1182(d); 42 USC 300gg-4(d); and 42 USC 300gg-53(e).
[8] *See* 45 CFR 164.502(a)(5)(i)(4)(B).
[9] Perry W. Payne, Jr. et al, *Health Insurance and the Genetic Information Nondiscrimination Act of 2008: Implications for Public Health Policy and Practice*, Public Health Rep., Vol. 124 (March-April 2009), 328, 331.
[10] Codified 42 USC 300gg, 29 USC 1181 et seq., and 42 USC 1320d et seq.
[11] *See* Payne at pg. 329.
[12] National Institutes of Health, *The Genetic Information Nondiscrimination Act (GINA)*.
[13] *See* 29 CFR 1635(a), which prohibits the use of genetic information in employment decision making; restricts employers and other entities from requesting, requiring, or purchasing genetic information; requires that genetic information be maintained as a confidential medical record, and places strict limits on disclosure of genetic information; and provides remedies for individuals whose genetic information is acquired, used, or disclosed in violation of GINA.

clearinghouse, other health care providers, and their business associates.[14] HIPAA provides standards for the use and disclosure of protected health information and generally prohibits covered entities and their business associates from disclosing protected health information, except as otherwise permitted or required.[15] Covered entities generally may not sell protected health information.[16] HIPPA, as modified by GINA, also prohibits health plans from using or disclosing protected health information that is genetic information for underwriting purposes.[17]

Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act of 2010 (ACA) requires all individual and group health plans to enroll applicants regardless of their health status, age, gender, or other factors that might predict the use of health services.[18] These guaranteed issue and guaranteed renewability requirements apply to genetic testing.

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

Federal law under GINA applies to all states and provides a baseline level of protection that states may exceed. The NIH has identified 105 state statutes addressing health insurance nondiscrimination across 48 states and the District of Columbia.[19] Fewer states address genetic testing regarding other lines of insurance such as life insurance, disability insurance, and long-term care insurance.[20]

Examples of such statutes include Oregon, which requires informed consent to conduct testing, prohibits the use of genetic information for underwriting or ratemaking for any policy for hospital and medical expense, and prohibits using the genetic information of a blood relative for underwriting purposes regarding any insurance policy.[21] Informed consent when an insurer requests genetic testing for life or disability insurance is required in California, New Jersey, and New York.[22] Massachusetts prohibits unfair discrimination because of the basis of genetic information or a genetic test and prohibits requiring an applicant or existing policyholder to undergo genetic testing.[23] Arizona prohibits the use of genetic information for underwriting or rating disability insurance in the absence of a diagnosis, and life and disability insurance policies may not use genetic information for underwriting or ratemaking unless supported by the applicant's medical condition, medical history, and either claims experience or actuarial projections.[24]

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[14] See 45 CFR 160.103.
[15] See 45 CFR 164.502(a).
[16] See 45 CFR 164.502(a)(5)(ii)(A).
[17] See 45 CFR 164.502(a)(5)(i).
[18] See 42 USC 300gg-1 and 42 USC 300gg-2.
[19] National Institutes of Health, *Genome Statute and Legislation Database Search*. https://www.genome.gov/policyethics/legdatabase/pubsearch.cfm (database search for "state statute," "health insurance nondiscrimination" performed by Committee on Banking and Insurance professional staff on Feb. 2, 2018).
[20] *See id*. (database search for "state statute," "other lines of insurance nondiscrimination" performed by Committee on Banking and Insurance professional staff on Feb. 2, 2018).
[21] Section 746.135, O.R.S.
[22] *See* Cal. Ins. Code s. 10146 et seq.; s. 17B:30-12, N.J.S.; and ISC s. 2615, N.Y.C.L.
[23] Chapter 175 sections 108I and 120E, M.G.L.
[24] Section 20-448, A.R.S.

Genetic Testing

Genetic testing includes a number of medical tests that identify and examine chromosomes, genes, or proteins for the purpose of obtaining genetic information.[25] Genetic testing is often used for medical or genealogical purposes.

Medical Genetic Testing

Genetic testing can be done to diagnose a genetic disorder, to predict the possibility of future illness, and predict a patient's response to therapy.[26] More than 2,000 genetic tests are currently available and more tests are constantly being developed.[27] The National Institutes of Health[28] (NIH) have identified the following available types of medical genetic testing:[29]

- *Diagnostic testing* identifies or rules out a specific genetic or chromosomal condition, and is often used to confirm a diagnosis when a particular condition is suspected based on the individual's symptoms. For example, a person experiencing abnormal muscle weakness may undergo diagnostic testing that screens for various muscular dystrophies.
- *Predictive and presymptomatic testing* is used to detect gene mutations associated with disorders that appear after birth, often later in life. This testing is often used by people who are asymptomatic, but have a family member with a genetic disorder. Predictive testing can identify mutations that will result in genetic disorder, or that increase a person's risk of developing disorders with a genetic basis, such as cancer.
- *Carrier testing* identifies people who carry one copy of a gene mutation that, when present in two copies, causes a genetic disorder. This test is often used by parents to determine their risk of having a child with a genetic disorder.
- *Preimplantation testing* is used to detect genetic changes in embryos developed by assisted reproductive techniques such as in-vitro fertilization. Small numbers of cells are taken from the embryos and tested for genetic changes prior to implantation of a fertilized egg.
- *Prenatal testing* detects changes in a baby's genes or chromosomes before birth. Such testing is often offered if there is an increased risk the baby will have a genetic or chromosomal disorder.
- *Newborn screening* is performed shortly after birth to identify genetic disorders that can be treated early in life. Florida screens for 31 disorders recommended by the United States Department of Health and Human Services Recommended Uniform Screening Panel and 22 secondary disorders, unless a parent objects in writing.[30]

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[25] National Institutes of Health, *Genetic Testing*, pg. 3 (January 30, 2018). Available for download at https://ghr.nlm.nih.gov/primer/testing/uses (last accessed January 31, 2018).
[26] Francis S. Collins, *A Brief Primer on Genetic Testing* (January 24, 2003). https://www.genome.gov/10506784/a-brief-primer-on-genetic-testing/ (last accessed January 31, 2018).
[27] *See* Ohio State University Wexner Medical Center, *Facts About Testing*. https://wexnermedical.osu.edu/genetics/facts-about-testing (last accessed February 1, 2018).
[28] The National Institutes of Health is the medical research agency of the United States federal government. The NIH is part of the United States Department of Health and Human Services. The NIH is made of 27 different Institutes and Centers, each having a specific research agenda.
[29] *See* National Institutes of Health, *Genetic Testing*, at pgs. 5-6.
[30] Florida Department of Health, *Newborn Screening*. http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/index.html (last accessed January 31, 2018).

Genetic testing is often used for research purposes. For example, genetic testing may be used to discover genes or increase understanding of genes that are newly discovered or not well understood.[31] Testing results as part of a research study are usually not available to patients or healthcare providers.[32]

The Human Genome Project, which in April 2003 successfully sequenced and mapped all of the genes of humans, and a variety of other genetic testing has led to multiple medical advances. For example, genetic testing identified that the reason the drug Plavix, which is commonly used to prevent blood clots in patients at risk for heart attacks and strokes, does not work for approximately 30 percent of the United States population because variations in the CYP2C19 gene account for the lack of a response.[33] Thus genetic testing can identify persons for whom the drug will not be effective.

The American Medical Association supports broad protections against genetic discrimination because it believes genetic testing and genetic information is essential to advancements in medical knowledge and care.[34] Accordingly, the organization supports comprehensive federal protection against genetic discrimination because "patients remain at-risk of discrimination in a broad array of areas such as life, long-term care, and disability insurance as well as housing, education, public accommodations, mortgage lending, and elections."

Methods of genetic testing used for medical purposes include:

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

Genetic Ancestry Testing

Genetic ancestry testing, also called genetic genealogy, is used to identify relationships between families and identify patterns of genetic variation that are often shared among people of particular backgrounds.[35] According to the National Institutes of Health (NIH), genetic ancestry testing results may differ between providers because they compare genetic information to different databases. The tests can yield unexpected results because human populations migrate and mix with other nearby groups. Scientists can use large numbers of genetic ancestry test

[31] *See* fn. 27, Ohio State University Wexner Medical Center.
[32] National Institutes of Health, *Genetic Testing*, at pg. 24.
[33] Francis S. Collins, Perspectives on the Human Genome Project, pg. 50 (June 7, 2010) https://www.genome.gov/pages/newsroom/webcasts/2010sciencereportersworkshop/collins_nhgrisciencewriters060710.pdf (last accessed Feb. 4, 2018).
[34] American Medical Association, *Genetic Discrimination – Appendix II. AMA Legislative Principles on Genetic Discrimination and Surreptitious Testing*, (March 2013) https://www.ama-assn.org/sites/default/files/media-browser/public/genetic-discrimination-policy-paper.pdf (last accessed Feb 4, 2018).
[35] National Institutes of Health, *Genetic Testing*, at pg. 25.

results to explore the history of populations. Three common types of genetic ancestry testing include:[36]

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

Direct to Consumer Genetic Testing

Traditionally, genetic testing was available only through healthcare providers.[37] Direct-to-consumer genetic testing provides access to genetic testing outside the healthcare context. Generally, the consumer purchases a genetic testing kit from a vendor who mails the kit to the consumer. The consumer collects a DNA sample and mails it back to the vendor. The vendor uses a laboratory to conduct the test. The consumer is then notified of the test results.

Direct-to-consumer genetic testing has primarily been used for genealogical purposes, but increasing numbers of products now provide medical information. For example, the vendor 23andME offers, with FDA approval, genetic testing that examines the consumer's risks for certain diseases including Parkinson's disease, celiac disease, and late-onset Alzheimer's disease.[38]

Direct to consumer genetic testing is increasing in popularity, with one company reporting having sold approximately 1.5 million genetic testing kits from November 24, 2017, through November 27, 2017.[39] The increased proliferation of such testing is accompanied by increased concerns about the privacy of such information. The privacy protections of HIPAA usually do not apply to direct-to-consumer genetic testing because the vendors selling such tests are often not "covered entities" and thus not subject to HIPAA. The Federal Trade Commission recently warned consumers to consider the privacy implications of genetic testing kits.[40]

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

Life insurance is the insurance of human lives.[41] Life insurance can be purchased in the following forms:[42]

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[36] National Institutes of Health, *Genetic Testing*, at pg. 26.
[37] National Institutes of Health, *Genetic Testing*, at pg. 11.
[38] 23andMe, *Find Out What Your DNA Says About Your Health, Traits and Ancestry* https://www.23andme.com/dna-health-ancestry/ (last accessed Feb. 4, 2018).
[39] Megan Molteni, *Ancestry's Genetic Testing Kits Are Heading For Your Stocking This Year*, Wired, Dec. 1, 2017, https://www.wired.com/story/ancestrys-genetic-testing-kits-are-heading-for-your-stocking-this-year/ (last accessed Feb. 3, 2018).
[40] Federal Trade Commission, *DNA Test Kits: Consider the Privacy Implications*, (Dec. 12, 2017) https://www.consumer.ftc.gov/blog/2017/12/dna-test-kits-consider-privacy-implications (last accessed Feb. 3, 2018).
[41] Section 624.602, F.S.
[42] National Association of Insurance Commissioners, *Life Insurance – Considerations for All Life Situations*, http://www.insureuonline.org/insureu_type_life.htm (last accessed Feb. 3, 2018).

- Term life insurance provides coverage for a set term of years and pays a death benefit if the insured dies during the term.[43]
- Permanent life insurance remains in place if the insured pays premiums and pays a death benefit. Such policies have an actual cash value component that increases over time and from which the policyowner may borrow. There are four types of permanent life insurance:
  - Whole life insurance offers a fixed premium, guaranteed annual cash value growth and a guaranteed death benefit. It does not provide investment flexibility and the policy coverage, once established, may not be changed.
  - Universal life insurance allows the policyholder to determine the amount and timing of premium payments within certain limits. The coverage level may be adjusted. It guarantees certain levels of annual cash value growth but not investment flexibility.
  - Variable life insurance allows allocation of investment funds, but does not guarantee minimum cash value because of fluctuations in the value of investments.
  - Variable universal life insurance combines variable and universal life insurance.

Life insurance also encompasses annuities and disability policies.[44] An annuity is a contract between a customer and an insurer wherein the customer makes a lump-sum payment or a series of payments to an insurer that in return agrees to make periodic payments to the annuitant at a future date, either for the annuitant's life or a specified period. Disability insurance pays a weekly or monthly income for a set period if the insured becomes disabled and cannot continue working or obtain work.

Life insurance underwriters seek to identify and classify the risk represented by a proposed insured and then classify those risks into pools of similar mortality or morbidity risk.[45] Insureds within the same risk classification pay the same premiums, which must be adequate to ensure solvency, pay claims, and provide the insurer (with investment income) a reasonable rate of return.

Disability insurance compensates the insured for a portion of income lost because of a disabling injury or illness.[46] There are two types of disability insurance: short-term and long-term. A short-term policy typically replaces a portion of lost income from 3 to 6 months following the disability. Long-term policies generally begin 6 months after the disability and can last a set number of years or until retirement age. Disability insurance is sometimes offered by life insurers.

Insurance policy forms must be filed and approved by the OIR.[47] The Unfair Insurance Trade Practices Act prohibits "knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class and expectation of life, in the rates charged

[43] National Association of Insurance Commissioners, *Life Insurance FAQs*, http://www.insureuonline.org/consumer_life_faqs.htm (last accessed Feb. 3, 2018).
[44] Section 624.602, F.S.
[45] American Council of Life Insurers, *Life Insurer Issues*. (On file with the Senate Committee on Banking and Insurance).
[46] *See* National Association of Insurance Commissioners, *A Worker's Most Valuable Asset: Protecting Your Financial Future with Disability Insurance* http://www.naic.org/documents/consumer_alert_protecting_financial_future_disability_insurance.htm (last accessed Feb. 5, 2018).
[47] Section 624.410, F.S.

for a life insurance or annuity contract, in the dividends or other benefits payable thereon, or in any other term or condition of such contract."[48] Similarly, the act prohibits knowingly making or permitting unfair discrimination between individuals of the same actuarially supportable class, as determined at the time of initial issuance of the coverage, and essentially the same hazard, in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance, in benefits payable, in the terms or conditions of the contract, or in any other manner.[49]

Long-term care (LTC) insurance covers the costs of nursing homes, assisted living, home health care, and other long-term care services. A long-term care insurance policy provides coverage for medically necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital.[50] Long-term care insurance usually pays fixed-dollar amounts or the actual costs of care, often subject to a maximum daily benefit amount.[51]

The long-term insurance market provides an example of the negative effects of insurers not accurately projecting their underwriting risk. Long-term care insurers made incorrect assumptions when selling the coverage, particularly in the 1980s and 1990s.[52] The LTC insurers overestimated the number of people that would cancel their coverage or allow it to lapse, underestimated the life span of insureds and the time span of the treatment they would receive, and overestimated earnings on LTC premiums which were negatively affected by dropping interest rates.[53] As a result, long-term care insurance premiums have been rising, often substantially, for the past decade.[54]

In response to substantial LTC premium increases, Florida law prohibits LTC rate increases that would result in a premium in excess of that charged on a newly issued policy, except to reflect benefit differences.[55] If the insurer is not writing new LTC policies, the rate cannot exceed the new business rate of insurers representing 80 percent of the carriers in the marketplace. In January 2017, the OIR issued consent orders allowing two of the state's largest LTC insurers, Metropolitan Life Insurance Company and Unum Life Insurance Company of America, to substantially raise LTC monthly premiums, phased in over 3 years.[56] Many insurers that write

[48] Section 626.9541(1)(g)1., F.S.
[49] Section 626.9541(1)(g)2., F.S.
[50] Section 627.9404(1), F.S.
[51] Florida Department of Financial Services, Long-Term Care: A Guide for Consumers, pg. 5. https://www.myfloridacfo.com/division/consumers/UnderstandingCoverage/Guides/documents/LTCGuide.pdf (last accessed February 3, 2018).
[52] *See* Leslie Scism, *Millions Bought Insurance to Cover Retirement Health Costs. Now They Face an Awful Choice*, Wall Street Journal, January 17, 2018. https://www.wsj.com/articles/millions-bought-insurance-to-cover-retirement-health-costs-now-they-face-an-awful-choice-1516206708 (last accessed February 3, 2018).
[53] *See* Office of Insurance Regulation, *Long-Term Care Public Rate Hearings*. (The Internet page references a rate filing decision made by the OIR on Jan. 12, 2017, related to LTC products for two insurers). https://www.floir.com/Sections/LandH/LongTermCareHearing.aspx (last accessed February 3, 2018); See Scism at fn. 35
[54] *See* Scism at fn. 35; See Office of Insurance Regulation at fn. 36. https://www.floir.com/Sections/LandH/LongTermCareHearing.aspx (last accessed February 3, 2018).
[55] Section 627.9407(7)(c), F.S.
[56] *See* Office of Insurance Regulation, *Consent Order In the Matter of: Metropolitan Life Insurance Company*, Case No. 200646-16-CO (Jan. 12, 2017) https://www.floir.com/siteDocuments/MetLife200646-16-CO.pdf (last accessed Feb. 3, 2018); Office of Insurance Regulation, *Consent Order In The Matter of Unum Life Insurance Company of America*, Case No. 200879-16-CO (Jan. 12, 2017) https://www.floir.com/siteDocuments/Unum200879-16-CO.pdf (last accessed Feb. 3, 2018).

LTC insurance have taken substantial losses. Recently, General Electric announced a $6.2 billion charge against earnings and a $15 billion shortfall in insurance reserves related to long-term care insurance obligations.[57]

The American Council of Life Insurers has expressed concerns that the proliferation of genetic testing could increase adverse selection and impact the availability and affordability of products over time.[58] Studies addressing whether genetic testing leads to adverse selection have reached varying conclusions. Studies of women tested for the BRCA1 gene mutation (linked to breast cancer risk)[59] and adults tested for Alzheimer's risk[60] found little evidence of adverse selection in the life insurance market. However, the study regarding Alzheimer's risk found evidence of adverse selection for long-term care insurance, as 17 percent of those who tested positive subsequently changed their LTC policy in the year after testing positive of Alzheimer's risk, in comparison with 2 percent of those who tested negative and 4 percent of those who did not receive test results.[61]

III. Effect of Proposed Changes:

Section 1 amends s. 627.4301, F.S., to prohibit life insurers, including life insurers providing disability insurance, and long-term care insurers from canceling, limiting, or denying coverage or establishing differentials in premium rates, based on genetic information, if there is no diagnosis of a condition related to the genetic information. The bill also prohibits life insurers and long-term care insurers from requiring or soliciting genetic information, or considering a person's decisions or actions relating to genetic testing in any manner for any insurance purpose. The bill amends the existing prohibition against health insurers using genetic test results in any manner for any insurance purpose to apply only in the absence of a diagnosis of a condition related to genetic information, and applies the prohibition to life insurers and long-term care insurers.

The bill repeals current law that exempts insurance policies for life, disability, or long-term care from s. 627.4301, F.S.

For purposes of s. 627.4301, F.S., the bill defines the following terms:

- "Life insurer" has the same meaning as in s. 624.602, F.S., and includes an insurer issuing life insurance contracts that grant additional benefits if the insured is disabled. Section 624.602, F.S., defines a life insurer as an insurer engaged in the business of issuing

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[57] Sonali Basak, Katherine Chiglinsky, et al, *GE's Surprise $15 Billion Shortfall Was 14 Years in the Making*, Chicago Tribune, January 25, 2018. http://www.chicagotribune.com/business/ct-biz-ge-general-electric-accounting-20180125-story.html (last accessed February 3, 2018); Steve Lohr and Chad Bray, *At G.E., $6.2 Billion Charge for Finance Unit Hurts C.E.O.'s Turnaround Push*, New York Times, Jan. 16, 2018. https://www.nytimes.com/2018/01/16/business/dealbook/general-electric-ge-capital.html (last accessed February 3, 2018).

[58] Gina Kolata, *New Gene Tests Pose a Threat to Insurers*, New York Times (May 12, 2017) https://www.nytimes.com/2017/05/12/health/new-gene-tests-pose-a-threat-to-insurers.html (last accessed Feb. 4, 2018).

[59] Cathleen D. Zick, et. al., *Genetic Testing, Adverse Selection, and the Demand for Life Insurance*, pgs. 29-39 American Journal of Medical Genetics (July 2000) (Abstract provided by NIH at https://www.ncbi.nlm.nih.gov/pubmed/10861679 (last accessed Feb. 4, 2018)).

[60] Cathleen D. Zick, *Genetic Testing For Alzheimer's Disease And Its Impact on Insurance Purchasing Behavior*, pgs. 483-490, Health Affairs vol. 23, no. 2 (March/April 2005) https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.483 (last accessed Feb. 4, 2018).

[61] *See* Zick fn. 60 at pgs. 487-488.

life insurance contracts, including contracts of combined life and health and accident insurance.

- "Long-term care insurer" means an insurer that issues long-term care insurance policies as described in s. 627.9404, F.S.

Section 2 applies the act to policies entered into or renewed after January 1, 2019.

Section 3 provides an effective date of July 1, 2018.

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 may lead to more individuals undergoing genetic testing, which in the aggregate will lead to advancements in medicine and, regarding the individual, can be useful in identifying and treating disease and disability.

The bill, to the extent it encourages adverse selection of life, disability, or long-term care insurance, could result in the improper classification of risks for such policies, leading to inadequate rates and, eventually, higher premiums. Such insurers use of genetic information in underwriting, risk classification, and ratemaking could result in individuals either not being able to procure such coverages because the insurer is unwilling to offer the coverage, or offers it at a rate that is unaffordable to the consumer.

C. Government Sector Impact:

The bill does not fiscally impact the Office of Insurance Regulation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 627.4301 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 February 6, 2016:
The committee substitute amends the existing prohibition against health insurers using genetic test results in any manner for any insurance purpose to apply only in the absence of a diagnosis of a condition related to genetic information, and applies the prohibition to life insurers and long-term care insurers.

B. Amendments:

None.

780580

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2018	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete line 53
and insert:
genetic test results in the absence of a diagnosis of a condition related to genetic information, or consider a person's decisions or

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

780580

Delete line 10

and insert:

insurance purpose; revising a prohibition on the use of genetic test results by health insurers; revising and providing

By Senator Bean

4-01646A-18 20181106__

A bill to be entitled

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

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

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

627.4301 Genetic information for insurance purposes.—

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

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

4-01646A-18 20181106__

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

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

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

(2) USE OF GENETIC INFORMATION.—

(a) In the absence of a diagnosis of a condition related to genetic information, no health insurer, life insurer, or long-term care insurer authorized to transact insurance in this state may cancel, limit, or deny coverage, or establish differentials in premium rates, based on such information.

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

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

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

Section 2. This act applies to policies entered into or renewed on or after January 1, 2019.

Section 3. This act shall take effect July 1, 2018.

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Committee on Banking and Insurance

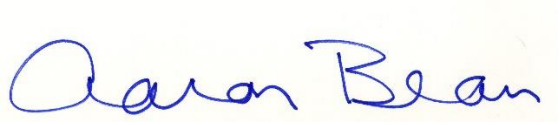
Subject: Committee Agenda Request

Date: December 18, 2017

I respectfully request that **Senate Bill # 1106**, relating to Genetic Information Used for Insurance, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.



Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/2018
Meeting Date

1106
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Genetic Information Used for Insurance

Name Tom Joos

Job Title State Legislative Affairs Manager

Address 12902 Magnolia Drive
Street

Phone 321-439-0766

Tampa *City* | Fl *State* | 33612 *Zip*

Email thomas.joos@moffitt.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Moffitt Cancer Center

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

SB 1106
Bill Number (if applicable)

Topic SB 1106

Amendment Barcode (if applicable)

Name BRUCE MARGOLIS

Job Title MEDICAL DIRECTOR

Address 3026 Sunny Ridge Dr
Street

Phone 434-363-2656

Odenton MD 21113
City *State* *Zip*

Email bruce.margolis@pacificlife.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing American Council of Life Insurers (ACLI)

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-6-18
Meeting Date

1101
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name Paul Sanford

Job Title _____

Address 106 S. Monroe St
Street

Phone 222-7200

Tallahassee FL 32301
City *State* *Zip*

Email _____

Speaking: ☐ For ☒ Against ☐ Information

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

Representing FIC - ACLU

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1126
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Licensure of Check Cashers and Foreign Currency Exchangers
DATE:	February 8, 2018 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1126 exempts additional check cashers from licensure by the Office of Financial Regulation (OIR) if the aggregate amount of payment instruments cashed is between $2,000 and $7,500 per person per day, and the check cashers meet certain additional conditions. These conditions include that the payment instruments are incidental to the retail sale of goods or services; and the person's compensation for cashing payment instruments at each location does not exceed 5 percent of the total gross income from the retail sale of goods or services by such person during the last 60 days. Further, these authorized check cashers must also comply with data submission and recordkeeping requirements prescribed by rule.

Current law provides an exemption from the check cashing licensure requirements for a person who cashes payment instruments that have an aggregate face value of less than $2,000 per person per day that are incidental to the retail sale of goods; and whose compensation for cashing payment instruments at each site does not exceed 5 percent of the total gross income from the retail sale of goods or services provided by such person during the last 60 days.

II. Present Situation:

Legitimate check cashing businesses serve a widely recognized social and economic purpose for a significant number of people, many of whom are economically disadvantaged and cannot or do not maintain accounts with traditional financial institutions. However, in recent years, two

primary categories of criminals, drug diverters[1] defrauding Medicaid and employers defrauding workers' compensation carriers, have been identified as relying on check cashing stores to enable their criminal activity. Further, parts of Florida continue to be identified as high intensity drug trafficking areas and high intensity financial crime areas.

The United States Drug Enforcement Agency has identified Florida as a significant center of illegal drug production, manufacturing, importation, or distribution. The High Intensity Drug Trafficking Areas (HIDTA) program, created by Congress with the Anti-Drug Abuse Act of 1988, provides assistance to federal, state, local, and tribal law enforcement agencies operating in areas determined to be critical drug-trafficking regions of the United States. There are currently 28 HIDTAs, which include approximately 18 percent of all counties in the United States and 66 percent of the U.S. population. HIDTA-designated counties are located in 49 states.[2] Florida contains four HIDTA-designated counties.[3] Further, the United States Financial Crimes Enforcement Network has designated eight counties in south Florida[4] as High Intensity Financial Crime Areas (HIFCAs)[5] in the United States. The HIFCAs are a means of concentrating law enforcement efforts at the federal, state, and local levels in high intensity money laundering zones.[6]

2008 Statewide Grand Jury Report on Check Cashers

In August 2007, the Supreme Court of Florida ordered the empanelment of a statewide grand jury to investigate various criminal offenses, including activities relating to check cashers. In 2008, the grand jury issued its report: *Check Cashers: A Call for Enforcement*.[7] The report documented hundreds of millions of dollars in illicit profits were being laundered in check cashing stores. This laundering was facilitating hundreds of millions of dollars in Medicaid and Medicare fraud, workers' compensation fraud, and many other types of criminal activity.

The dollar magnitude of this fraud is tremendous. The report noted that in one investigation, the Department of Financial Services found that 10 construction companies funneled $1 billion through check cashing stores over a 3-year period.[8] A typical fraud scheme involves a facilitator's creation of a fake shell company and purchase of a minimal workers' compensation insurance policy in the name of the shell company. The facilitator then "rents" the shell company's name and workers' compensation insurance policy to uninsured subcontractors, who are otherwise unable to find work without the workers' compensation insurance. After the

[1] Drug diversion is the practice of diverting pharmaceutical drugs from legitimate sources and reselling them on the black market. See 2008 Statewide Grand Jury Report on Check Cashers section, below, for further discussion.
[2] U.S. Drug Enforcement Agency, HIDTA Areas, (Feb. 2017) available at https://www.dea.gov/ops/hidta.shtml (last viewed Jan. 29, 2018).
[3] *Id.*
[4] Broward, Miami-Dade, Indian River, Martin, Monroe, Okeechobee, Palm Beach and St Lucie counties.
[5] Financial Crimes Enforcement Network, HIFCA, available at https://www.fincen.gov/hifca (last viewed Jan. 30, 2018).
[6] The Money Laundering and Financial Crimes Strategy Act of 1998, P.L. 105-310 (October 30, 1998), requires the designation of certain areas as areas in which money laundering and related financial crimes are extensive or present a substantial risk shall be an element of the national strategy developed pursuant to section 5341(b) of the Act. See 31 U.S. Code 5341(b) and 5342(b).
[7] Eighteenth Statewide Grand Jury, Case No. SC 07-1128, Second Interim Report of the Statewide Grand Jury, *Check Cashers: A Call for Enforcement,* (Mar. 2008) (on file with Senate Banking and Insurance Committee).
[8] *Id.*

subcontractor completes work under the guise of the shell company, the general contractor pays the subcontractor wages with a company check made payable to the shell company. However, most banks generally do not cash checks made out to businesses or third parties, but rather will require that the check be deposited into the payee's bank account. Thus, the subcontractors take their checks to nonbank check cashers, who, until 2012, could cash third-party business-to-business checks by certain persons "authorized" by the payee. In response, the Legislature enacted legislation in 2008 to provide the OFR and law enforcement with additional tools to combat these fraudulent activities.[9] However, workers' compensation fraud involving shell companies continued to increase.

Chief Financial Officer's Work Group

In 2011, the Chief Financial Officer convened a work group[10] of regulators (including the OFR), law enforcement, and industry stakeholders to study the issue of workers' compensation premium fraud, with particular regard to the role that check cashers play in facilitating the fraudulent schemes. The report noted that one shell company alone accounted for $27 million worth of checks in excess of $10,000 over a 4-year period. In addition, the Work Group estimated that this fraud costs the state up to $1 billion annually. The resulting unreported payroll taxes, unreported premium taxes, and higher costs to insurance carriers who must process workers' compensation claims from uninsured workers adversely affect law-abiding businesses, which absorb the resulting costs of this fraud.

The work group provided a number of significant recommendations to fight workers' compensation fraud, which were enacted by the Legislature in 2012.[11] However, one recommendation of the work group, the establishment of a statewide, real-time database for regulators and law enforcement to quickly and effectively detect and deter workers' compensation premium fraud was not enacted until 2013. [12]

Florida's Regulation of Check Cashers

The Office of Financial Regulation (OFR) regulates the money services businesses, which covers payment instrument sellers, check cashers, foreign currency exchangers, and deferred presentment providers, pursuant to ch. 560, F.S., the Money Services Business Act (act). A check casher is a person who sells currency in exchange for receiving a check, draft, warrant, money order, electronic instrument, or other instrument, payment of money, or monetary value whether or not negotiable.[13]

Section 560.304, F.S., provides an exemption from the check cashing licensure requirements for a person:

- Who cashes payment instruments that have an aggregate face value of less than $2,000 per person per day that are incidental to the retail sale of goods; and

[9] Ch. 2008-177, Laws of Fla.
[10] Department of Financial Services, *A Report by the Money Services Business-Facilitated Workers' Compensation Fraud Work Group*, (2011) (on file with the Senate Committee on Banking and Insurance).
[11] Ch. 2012-85, Laws of Fla.
[12] Ch. 2013-139, Laws of Fla.
[13] Section 560.103, F.S.

- Whose compensation for cashing payment instruments at each site does not exceed 5 percent of the total gross income from the retail sale of goods or services provided by such person during the last 60 days.

Section 560.1401, F.S., provides that an applicant for licensure as a money services business must:

- Demonstrate the character and general fitness to command the confidence of the public and warrant the belief that the money services business shall operate lawfully and fairly;
- Be legally authorized to do business in this state;
- Be registered as a money services business with the Financial Crimes Enforcement Network;[14] and,
- Have an anti-money laundering program, which meets the requirements of 31 C.F.R. s. 1022.210.

Section 560.309, F.S., prohibits licensed check cashers from charging fees in excess of:

- 10 percent of the face amount of a personal check, or $5, whichever is greater;
- 3 percent of the face amount of public assistance or federal social security benefit checks, or $5, whichever is greater; or
- 5 percent of the face amount of all other checks, or $5, whichever is greater.

Section 560.123, F.S., requires the maintenance of certain records of each transaction involving currency or payments instruments in order to deter the use of a money services business to conceal proceeds from criminal activity and to ensure the availability of such records for criminal, tax, or regulatory investigations or proceedings. For example, a money services business must keep records of each transaction occurring in this state that it knows to involve currency or other payment instruments having a greater value than $10,000.

Further, s. 560.310, F.S., requires licensees engaged in check cashing to maintain specific documents and enter information into the CCDB, as applicable. Licensed check cashers are required to enter the following transactional data into the check-cashing database (CCDB) before cashing a check over $1,000:

- Transaction date;
- Payor name;
- Conductor[15] name, if different from payee name;
- Type of payment instrument, amount of payment instrument and amount of currency provided;
- Amount of fee charged;
- Location where the check was cashed; and
- The type of identification and identification number presented by the payee or conductor.

[14] See 31 C.F.R. 1010.100 and 31 C.F.R. 1022.380. These provisions defines money service businesses subject to registration with the Financial Crimes Enforcement Network (FinCEN), to include persons that cash checks or monetary instruments in an amount greater than $1,000 per person, per day.

[15] Section 560.103(9), F.S., defines a "conductor" as a natural person who presents himself or herself to a licensee for purposes of cashing a payment instrument.

OFR Check Cashing Database

According to a recent statistical analysis by the OFR of data contained in the check-cashing database (CCDB) and reported by licensed check cashers:

- Approximately 94 percent of all checks recorded in the CCDB since inception date of September 3, 2015, were under $7,500.
- Over 86 percent of all corporate checks recorded in the CCDB since the inception date of September 3, 2015, were under $7,500.
- Over 93 percent of all Internal Revenue Service tax-refund checks recorded in the CCDB since the inception date of September 3, 2015, were under $7,500.[16]

The OFR has eight memorandum's of understanding (MOU) that allow sharing of data from the CCDB with federal, state, or local governments that use this information to identify and prosecute various forms of fraud:

- Office of the State Attorney – 17th Judicial Circuit
- Broward County Sherriff's Office
- Department of Economic Opportunity
- Fort Lauderdale Police Department
- Internal Revenue Service – Criminal Investigations – Tampa and Miami Offices
- Department of Financial Services, Division of Workers' Compensation and the Division of Forensic and Investigative Services.

The Department of Financial Services uses the CCDB to assist them in investigating compliance with workers' compensation coverage requirements, insurance fraud, and other illegal activities.[17] The Division of Workers' Compensation (DWC) uses the OFR's check cashing store database, which contains critical financial information on the amount of payments cashed by employers to identify employers who may be underreporting payroll and initiate the DWC's enforcement actions against these employers. The DWC has used the check cashing store database to issue approximately 30 Stop-Worker Orders against employers who have underreported payroll to their insurance companies. The amount of unreported payroll was approximately $323 million. The Division of Investigative and Forensic Services of the Department of Financial Services uses the information contained in the database to assist them in their investigation of money laundering, workers' compensation premium fraud, and Medicaid fraud.

III. Effect of Proposed Changes:

Section 1 amends s. 560.304, F.S., to create a new exemption from licensure under part III of ch. 560, F.S., for a person who is authorized by the office to cash payment instruments that have an aggregate face value of between $2,000 and $7,500 per person per day and that are incidental to the retail sale of goods or services, and whose compensation for cashing payment instruments at each site does not exceed 5 percent of the total gross income from the retail sale of goods or services by such business during the last 60 days.

[16] Office of Financial Regulation, *Analysis of SB 1126,* (Jan. 9, 2018) (on file with Senate Committee on Banking and Insurance).
[17] Department of Financial Services, *Analysis of SB 1126* (Dec. 21, 2017) (on file with Senate Committee on Banking and Insurance).

The OIR must authorize such person if the person:

- Submits all data collected in the course of business for checks with a face value exceeding $2,000 on a daily basis to support the detection and prosecution of financial crime and workers' compensation violations;
- Provides records prescribed by commission rule and requested by the office in the course of a criminal investigation;
- Establishes limits on the aggregate value of cashed instruments over a monthly and yearly timeframe which do not exceed the maximum amount specified in this paragraph, and reports the limits to the office pursuant to commission rule; and
- Does not cash corporate instruments.

Under current law, an exemption from licensure as a check casher is provided for a person whose cash payment instruments have an aggregate face value of less than $2,000, per person per day that are incidental to the retail sale of goods; and the compensation for cashing payment instruments at each site does not exceed 5 percent of the total gross income from the retail sale of goods or services provided by such person during the last 60 days.

Section 2 provides the bill will take effect July 1, 2018.

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:

Dependent upon the number of licensed check cashers that could avail themselves of the new exemption from licensure under the bill, an indeterminate number of businesses would no longer be subject to OFR licensure application and renewal fees. There is no fee required for the authorization process.

C. Government Sector Impact:

The impact is indeterminate since the number of businesses that could operate under the new exemption is unknown. The OFR states one FTE (Financial Specialist) is required to implement the provisions of the bill. Total recurring costs for this position would be $64,042.

D. Constitutional Issues:

The bill may raise the issue of an unlawful delegation of legislative authority to the executive branch. On lines 17-39, the bill provides that the Financial Services Commission will adopt rules to administer the authorization program and to implement recordkeeping requirements. However, the bill does not provide standards or conditions that would allow the OFR to deny authorizing, nonrenewing, or deauthorizing a check casher. Further, it is unclear whether the OFR could examine an authorized check casher to determine compliance with the provisions of the bill or impose administrative penalties or fines for noncompliance.

Article II, Section 3, of the Florida Constitution, establishes a doctrine of separation of powers, providing that no branch may exercise powers appertaining to the other branches. Interpreting this doctrine in the context of the Legislature delegating authority to the executive, the Florida Supreme Court has stated that, "where the Legislature makes the fundamental policy decision and delegates to some other body the task of implementing that policy under adequate safeguards, there is no violation of the doctrine." Askew v. Cross Key Waterways, 372 So.2d 913 (Fla. 1978). However, "[w]hen the statute is couched in vague and uncertain terms or is so broad in scope that no one can say with certainty, from the terms of the law itself, what would be deemed an infringement of the law, it must be held unconstitutional as attempting to grant to the administrative body the power to say what the law shall be." Conner v. Joe Hatton, Inc., 216 So.2d 209 (Fla. 1968).

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill provides an effective date of July 1, 2018; however, this may not allow adequate time to adopt rules to implement the bill.

VIII. Statutes Affected:

This bill substantially amends section 560.304 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on February 6, 2018:
The CS creates a new exemption from licensure under part III of ch. 560, F.S., for a person who is authorized by the Office of Financial Regulation to cash payment instruments that have an aggregate face value of between $2,000 and $7,500 per person per day and that are incidental to the retail sale of goods or services, and whose compensation for cashing payment instruments at each site does not exceed 5 percent of the total gross income from the retail sale of goods or services by such business during the last 60 days.

B. Amendments:

None.

228994

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2018	.	
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The Committee on Banking and Insurance (Brandes) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 560.304, Florida Statutes, is amended to read:

560.304 Exemption from licensure.—

(1) The requirement for licensure under this part does not apply to:

(a) A person cashing payment instruments that have an

228994

aggregate face value of less than $2,000 per person per day and that are incidental to the retail sale of goods or services, if the person's ~~whose~~ compensation for cashing payment instruments at each site does not exceed 5 percent of the total gross income from the retail sale of goods or services by such person during the last 60 days.

(b) A person who is authorized by the office to cash payment instruments that have an aggregate face value of between $2,000 and $7,500 per person per day and that are incidental to the retail sale of goods or services, and whose compensation for cashing payment instruments at each site does not exceed 5 percent of the total gross income from the retail sale of goods or services by such business during the last 60 days. The office must authorize such person if the person:

1. Submits all data collected in the course of business for checks with a face value exceeding $2,000 on a daily basis to support the detection and prosecution of financial crime and workers' compensation violations;

2. Provides records prescribed by commission rule and requested by the office in the course of a criminal investigation;

3. Establishes limits on the aggregate value of cashed instruments over a monthly and yearly timeframe which do not exceed the maximum amount specified in this paragraph, and reports the limits to the office pursuant to commission rule; and

4. Does not cash corporate instruments.

(2) The commission may adopt rules necessary to administer paragraph (1)(b).

228994

Section 2. This act shall take effect July 1, 2018.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the licensure of check cashers; amending s. 560.304, F.S.; providing an exemption from licensure under part III of ch. 560, F.S., for persons authorized by the Office of Financial Regulation to cash, subject to certain limitations, certain payment instruments within a specified aggregate face value range; requiring the office to authorize the person to cash such instruments without such licensure if specified conditions are met; authorizing the Financial Services Commission to adopt rules; providing an effective date.

By Senator Brandes

24-01281B-18 20181126__

A bill to be entitled

An act relating to the licensure of check cashers and foreign currency exchangers; amending s. 560.304, F.S.; revising the limit on the aggregate face value of certain payment instruments cashed by a certain person within a specified timeframe before the person is required to be licensed under part III of ch. 560, F.S.; providing an effective date.

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

Section 1. Section 560.304, Florida Statutes, is amended to read:

560.304 Exemption from licensure.—The requirement for licensure under this part does not apply to a person cashing payment instruments that have an aggregate face value of less than $7,500 ~~$2,000~~ per person per day and that are incidental to the retail sale of goods or services, if the person's ~~whose~~ compensation for cashing payment instruments at each site does not exceed 5 percent of the total gross income from the retail sale of goods or services by such person during the last 60 days.

Section 2. This act shall take effect July 1, 2018.

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: December 24, 2017

I respectfully request that **Senate Bill #1126**, relating to **Licensure of Check Cashers and Foreign Currency Exchangers**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 24

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

SB 1126
Bill Number (if applicable)

228994
Amendment Barcode (if applicable)

Topic SB 1126

Name Greg Oaks

Job Title Director, Division of Consumer Finance

Address 200 E Gaines St.
Street

Phone 850-410-9601

Tallahassee FL 32399
City *State* *Zip*

Email Greg.Oaks@flofr.com

Speaking: ☐ For ☐ Against ☒ Information

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

Representing FL OFR

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

SB 1126
Bill Number (if applicable)

228994
Amendment Barcode (if applicable)

Topic Speaking on SB 1126

Name Courtney Larkin

Job Title Government Relations

Address 200 E Gaines St.
Street

Phone 850. 410. 9601

Tallahassee, FL 32399
City *State* *Zip*

Email courtney.larkin@flofr.com

Speaking: ☐ For ☐ Against ☒ Information

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

Representing FL Office of Financial Regulation

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

The Florida Senate

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 1304
INTRODUCER:	Banking and Insurance Committee and Senator Young
SUBJECT:	Dockless Bicycle Sharing
DATE:	February 7, 2018
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1304 creates a regulatory framework for bicycle sharing companies operating in the state and would preempt any local governmental entity from limiting or preventing bicycle sharing companies within their jurisdiction that demonstrate compliance with all local laws and regulations applicable to other similar businesses seeking to do business or presently doing business within the jurisdiction.

As defined in the bill, "bicycle sharing company" means an entity that makes bicycles available for private use by reservation through an online application, software, or website. Bicycle sharing companies must provide for an interface allowing for the communication of certain notifications as well as requirements relating to regular maintenance. Bicycles made available for reservation by a bicycle sharing company must meet certain specifications and a bicycle sharing company is responsible for the maintenance of bicycles and the removal of inoperable or unsafe bicycles. Minor operators under the age of 18 must be accompanied by a user who is at least 18 years of age. Minors under 16 years of age must comply with helmet laws.

The bill provides that a person operating a bicycle sharing company in this state must maintain a current and valid combined single-limit policy of commercial general liability insurance coverage in the amount of at least $500,000 per occurrence for bodily injury and property damage. Bicycle sharing companies must register with the Division of Corporations at the Department of State and provide such registration to any governmental entity whose jurisdiction they operate within. The bill requires bicycle sharing companies to remove illegally parked

bicycles and secure bicycles in the event of a tropical storm or hurricane warning. Local governments may fine companies that fail to meet these requirements by amounts specified in the bill.

The bill specifies that an airport or seaport may designate locations for the staging and pickup of bicycles, a local government entity may contract with a bicycle sharing company for the placement of bicycle docking stations on public land, and that a local government entity may enforce violations under the uniform traffic code under ch. 316, F.S.

The bill has an effective date of July 1, 2018.

II. Present Situation:

Bicycle Regulation

Section 316.2065, F.S., regulates the operation of bicycles in Florida. Bicycle riders are generally subject to the same rights and duties that are applied to the driver of any other vehicle under state traffic laws codified in the State Uniform Traffic Control Law, ch. 316, F.S.[1]

The provisions of 16 C.F.R. part 1512, relate to consumer product safety, and provide for bicycle specifications, including mechanical and safety requirements as well as testing and certification standards and requirements.

Currently, the regulation of bicycle sharing companies is left up to local jurisdictions. Neither state nor federal laws regulate bicycle sharing companies or require general liability insurance coverage.

Bicycle Sharing Programs

Bicycle sharing programs allow users to rent available bicycles located at one or more unmanned, designated bicycle racks. The user unlocks the bicycle using information provided by or transmitted from the program's mobile application on their mobile phone, and the bicycle may be used according to the terms of the program agreement. Many jurisdictions require that the bicycle sharing company acquire a permit for operations.

Rental options vary by program, but generally allow some combination of a single use rate for a flat fee, or a weekly, monthly, or annual subscription allowing the member to rent a bicycle for either an unlimited number of rides or a certain number of minutes per day during the subscription period.[2] Some companies assess additional fees for locking the bicycle away from a designated bicycle rack or station.

Bicycle sharing companies often equip their bicycles with GPS technology. This allows users to locate bicycles available nearby via their mobile application and also allows the company to locate bicycles, track movement, calculate distance traveled, or apply geofencing technology to

[1] s. 316.2065(1), F.S.
[2] *See, e.g.,* Broward B-cycle https://broward.bcycle.com/; Juice Orlando Bike Share *https://juicebikeshare.com/#about.*

control where bicycles may be rented, returned, or parked. Some companies offer "rewards" to incentivize the transport or return of bicycles to certain locations.

Currently, a variety of bicycle sharing programs are offered by a number of companies in different local jurisdictions across the state.[3] Local governments in Florida, and across the country, have entered into public-private partnerships with bicycle sharing companies to facilitate bicycle sharing programs in their jurisdiction. Proponents of this approach cite the importance of such partnerships in the successful implementation of bicycle sharing programs in local communities.[4] Specific examples include the use of dockless bicycle sharing data to assist in local bicycle network planning, prioritization, and evaluation, and the use of local regulations to incentivize users to start or end their trip at a mass transit stop in order to combat first-mile, last-mile challenges.[5] Local partnership advocates believe that working closely with local governments is necessary to ensure that sufficient safety standards are in place, control over the public right-of-way is properly maintained, sensitive customer data is protected, and that bicycle sharing operations are tailored to the needs and characteristics of local communities.

Some local governments and bicycle sharing companies have entered into exclusive, long term contracts, effectively banning any other company from operating within that jurisdiction.[6]

Dockless Bicycles

The absence of designated bicycle racks, stations, or hubs to "dock" the bicycles when not in use distinguishes the "dockless" bicycle sharing model from more traditional bicycle sharing models. In the past few years, the dockless bicycle sharing industry has experienced tremendous growth both in the United States and abroad.[7]

Dockless bicycle companies require a smaller initial capital investment due to not having to set up expensive stations and sometimes do not require that rental fees be paid to the local

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[3] *See e.g.*, Florida Bicycle Associate, Florida Bike Share Programs http://floridabicycle.org/florida-bike-share-programs/;(Last viewed Feb. 7, 2018) Ryan Pfeffer, *America's first dockless bike-share company launches in Coral Gables*, TIMEOUT (Nov. 10, 2017) https://www.timeout.com/miami/blog/americas-first-dockless-bike-share-company-launches-in-coral-gables-111017 (Last viewed Feb. 7, 2018); Nancy Dahlberg, *You'll find more shared bikes around town — and pay less to use them, too*, MIAMI HERALD (Nov. 12, 2017) http://www.miamiherald.com/news/business/article183868451.html (Last viewed Feb. 7, 2018).

[4] *See* Letter from NASBA, Re: Opposition to SB 1304/HB 1033: Dockless Bicycle Sharing (Jan. 12, 2018, on file with Banking and Insurance Committee). The North American Bikeshare Association (NASBA) was formed to support, promote and enhance bikeshare across North America on behalf of its members, who represent a wide share of the bikeshare industry, including system owners, operators, host cities, equipment manufacturers and technology providers.
Letter from SPIN, Re: Opposition to HB 1033/SB1304: Dockless Bicycle Sharing (Jan. 10, 2018, on file with Banking and Insurance Committee). SPIN is a leading stationless bike sharing company in the United States, operating in over two-dozen markets.

[5] *Id.*

[6] Johana Bhuiyan and Rani Molla. *A bike-sharing war is coming to the U.S. as investors pour money into new entrants*, RECODE (Oct. 23, 2017) https://www.recode.net/2017/10/23/16496908/bike-sharing-dockless-limebike-ofo-motivate-citi-bike-spin (Last viewed Feb. 7, 2018).

[7] See, e.g. Evgeny Tchebotarev, *With Hundreds Of Millions Of Dollars Burned, The Dockless Bike Sharing Market Is Imploding*, FORBES (Dec. 16, 2017), https://www.forbes.com/sites/evgenytchebotarev/2017/12/16/with-hundreds-of-millions-of-dollars-burned-the-dockless-bike-sharing-market-is-imploding/#12fb1fa4543b (Last Viewed Feb. 7, 2018); Henry Grabar, *Docks Off*, SLATE (Dec. 18, 2017), https://slate.com/business/2017/12/dock-less-bike-share-is-ready-to-take-over-u-s-cities.html (Last viewed Feb. 7, 2018).

government.[8] Advocates of the dockless bicycle sharing model see dockless bicycles as a way for private industry to provide alternative transportation options with little or no up-front investment by local government.

Opponents of the dockless bicycle model highlight that, because the bicycles aren't locked to anything, there is the potential for bicycles to be left in inconvenient places such as in the middle of the sidewalk, blocking curb ramps and other ADA-sensitive locations, businesses and transit access points. Additionally, some cities have experienced problems with bicycles being thrown into bodies of water, stranded in trees, on rooftops, and other undesirable places.[9] In China, which experienced extreme growth of bicycle sharing companies, a number of companies are now going out of business and cities are experiencing problems with large numbers of dockless bicycles being dumped on public sidewalks.[10]

Home Rule and Preemption

Counties

A county without a charter has such power of self-government as provided by general[11] or special law, and may enact county ordinances not inconsistent with general law.[12] General law authorizes counties "the power to carry on county government"[13] and to "perform any other acts not inconsistent with law, which acts are in the common interest of the people of the county, and exercise all powers and privileges not specifically prohibited by law."[14]

Chapter 166, F.S., also known as the Municipal Home Rule Powers Act,[15] acknowledges the constitutional grant to municipalities of governmental, corporate, and proprietary power necessary to conduct municipal government, functions, and services.[16] Chapter 166, F.S., provides municipalities with broad home rule powers, respecting expressed limits on municipal powers established by the Florida Constitution, applicable laws, and county charters.[17]

Municipalities

Chapter 166, F.S., also known as the Municipal Home Rule Powers Act,[18] acknowledges the constitutional grant to municipalities of governmental, corporate, and proprietary power necessary to conduct municipal government, functions, and services.[19] Chapter 166, F.S.,

[8] *See* Bhuiyan & Molla. *A bike-sharing war is coming to the U.S. as investors pour money into new entrants*.
[9] Josh Cohen, *Seattle Test Will Lead to Regulating Dockless Bike-Share*, NEXT CITY (Dec. 21, 2017) https://nextcity.org/daily/entry/seattle-dockless-bikeshare-pilot-regulation (Last viewed Feb. 7, 2018).
[10] Michelle Toh, *China's Bike-Sharing Frenzy Has Turned Into A Bubble*, CNN Money (Dec. 29, 2017). http://money.cnn.com/2017/12/29/investing/china-bike-sharing-boom-bust/index.html (last viewed February 3, 2018).
[11] ch. 125, part I, F.S.
[12] FLA. CONST. art. VIII, s. 1(f).
[13] s. 125.01(1), F.S.
[14] s. 125.01(1)(w), F.S.
[15] s. 166.011, F.S.
[16] Local Government Formation Manual 2017-2018, p. 16.
[17] s. 166.021(4), F.S.
[18] s. 166.011, F.S.
[19] Local Government Formation Manual 2017-2018, p. 16.

provides municipalities with broad home rule powers, respecting expressed limits on municipal powers established by the Florida Constitution, applicable laws, and county charters.[20]

Section 166.221, F.S., authorizes municipalities to levy reasonable business, professional, and occupational regulatory fees, commensurate with the cost of the regulatory activity, including consumer protection, on such classes of businesses, professions, and occupations, the regulation of which has not been preempted by the state or a county pursuant to a county charter.

Local governments have broad authority to legislate on any matter that is not inconsistent with federal or state law. A local government enactment may be inconsistent with state law if (1) the Legislature "has preempted a particular subject area" or (2) the local enactment conflicts with a state statute. Where state preemption applies it precludes a local government from exercising authority in that particular area.[21] Florida law recognizes two types of preemption: express and implied. Express preemption requires a specific legislative statement; it cannot be implied or inferred.[22] Express preemption of a field by the Legislature must be accomplished by clear language stating that intent.[23] In cases where the Legislature expressly or specifically preempts an area, there is no problem with ascertaining what the Legislature intended.[24] In cases determining the validity of ordinances enacted in the face of state preemption, the effect has been to find such ordinances null and void.[25]

III. Effect of Proposed Changes:

Section 1 creates s. 341.851, F.S., relating to bicycle sharing.

Legislative Intent

The bill provides that it is the intent of the Legislature to provide Florida residents with access to innovative, environmentally friendly transportation options and to ensure the safety and reliability of bicycle sharing services within the state.

Definitions

The bill defines the following terms as they relate to the regulation of bicycle sharing:

- "Bicycle sharing company" means a person who makes bicycles, as defined in s. 316.003(3), F.S., available for private use by reservation through an online application, software, or website.
- “Docking station” means a bicycle rack controlled by a bicycle sharing company where bicycles may be parked.
- “Local governmental entity” means a county, municipality, special district, airport authority, port authority, or other local governmental entity or subdivision.

[20] s. 166.021(4), F.S.
[21] Wolf, *The Effectiveness of Home Rule: A Preemptions and Conflict Analysis*, 83 Fla. B.J. 92 (June 2009).
[22] *See City of Hollywood v. Mulligan*, 934 So.2d 1238, 1243 (Fla. 2006); *Phantom of Clearwater, Inc. v. Pinellas County*, 894 So.2d 1011, 1018 (Fla. 2d DCA 2005), approved in *Phantom of Brevard, Inc. v. Brevard County*, 3 So.3d 309 (Fla. 2008).
[23] *Mulligan*, 934 So.2d at 1243.
[24] *Sarasota Alliance for Fair Elections, Inc. v. Browning*, 28 So.3d 880, 886 (Fla. 2010).
[25] *See, e.g., Nat’l Rifle Ass’n of Am., Inc. v. City of S. Miami,* 812 So.2d 504 (Fla. 3d DCA 2002).

- "User" means a person at least 18 years of age who reserves a bicycle through a bicycle sharing company's online application, software, or website.

Minor Operators

The bill also states that a bicycle sharing company may allow a minor to operate a bicycle if accompanied by a user. Minor operators under the age of 16 must wear a helmet as required in s. 316.2065(3)(d), F.S.

Insurance Requirement

The bill provides that a person may not operate a bicycle sharing company in this state unless the person or entity maintains a current and valid combined single-limit policy of commercial general liability insurance coverage in the amount of at least $500,000 per occurrence for bodily injury and property damage. A local governmental entity may annually require a bicycle sharing company to provide proof of insurance. If proof of insurance is not provided, the local governmental entity may issue a fine no greater than $5,000 and may order the bicycle sharing company to cease and desist from operating within the local governmental entity's jurisdiction until such proof is provided.

Bicycle Requirements

The bill requires that bicycles made available for reservation by a bicycle sharing company must:
- Meet the requirements for bicycles set forth in 16 C.F.R. part 1512 and s. 316.2065, F.S.
- Prominently display the bicycle company's trade dress.
- Display an e-mail address and telephone number at which a user or operator may contact the bicycle sharing company for customer support.
- Be lawfully parked when not in use.

Bicycle Sharing Company Responsibilities

The bill requires a bicycle sharing company must register with the Division of Corporations of the Department of State and must provide such registration to any local governmental entity in whose jurisdiction the company operates. Failure to provide such registration can result in a fine up to $1,000.

The bill requires a bicycle sharing company to provide through its online application, software, or website:
- Notification that a rider of a bicycle must operate the bicycle in compliance with state and local law.
- An interface that enables a user to notify the bicycle sharing company of an issue relating to the safety or maintenance of a bicycle.

The bill specifies that a bicycle sharing company is responsible for:
- The maintenance and rebalancing of each bicycle that it makes available for reservation and the removal of any such bicycle that is for any reason inoperable or does not comply with state or federal requirements for bicycles.

- The securing of all company bicycles located in an area where a tropical storm of hurricane warning has been issued. Failure to comply with this requirement can result in a fine of no greater than $1,000.

A bicycle sharing company must remove an unlawfully parked company bicycle within 24 hours of being given notice of its location and identification number by a local governmental entity. The local governmental entity may immediately move an unlawfully parked company bicycle and place it in the nearest location where it does not endanger the safe movement of pedestrians or vehicles. A local governmental entity may impose a fine of up to $10 per bicycle, per day the bicycle is illegally parked, not to exceed $100 per bicycle, if the bicycle sharing company does not remove the bicycle within 24 hours of receiving notice. The local governmental entity may impound the illegally parked bicycle if the bicycle sharing company does not remove it within 10 days of receiving notice.

Preemption

The bill prohibits local governments from taking any action or adopt any local ordinance, policy, or regulation that is designed to limit or prevent a bicycle sharing company or any company engaged in the rental of bicycles from operating within its jurisdiction, provided that the company has demonstrated compliance with all local laws and regulations applicable to other similar businesses seeking to do business or presently doing business within that jurisdiction.

Lastly the bill does not prohibit:
- An airport or seaport from designating locations for staging, pickup, and other similar operations relating to bicycles at the airport or seaport;
- A local governmental entity from entering into agreements with bicycle sharing companies for the placement of docking stations on public land; or
- A local governmental entity from enforcing uniform traffic infractions under ch. 316, F.S.

Section 2 provides an effective date of July 1, 2018.

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:

To the extent that local governments currently collect exclusive fees from bicycle sharing companies, local governments will lose this source of revenue. However, the fiscal impact is unknown at this time.

B. Private Sector Impact:

The bill will create statewide uniform requirements for bicycle sharing companies and will allow any bicycle sharing company meeting the requirements of the bill to operate throughout Florida. This is likely to increase marketplace competition among bicycle sharing companies. Bicycle sharing companies may incur costs for complying with the insurance requirement of the bill; some companies already maintain coverage.

C. Government Sector Impact:

The bill does not allow a local governmental entity from banning all bicycle sharing companies from within their jurisdiction.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 341.851 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 February 6, 2018:
The CS:

- Includes all bicycle sharing companies that utilize an application.
- Defines user as a rider 18 years of age or older and allows only users can reserve a bicycle.
- Requires minors 17 years of age and under must be in the company of a user and minors under 16 years of age must wear a helmet as required in ch. 316, F.S.
- Defines docking station for those bicycle sharing companies that utilize them and allows local governmental entities to enter into agreements for the placement of docking stations on public land.

- Allows a local governmental entity to check once a year to see if a bicycle sharing company has the proper level of insurance coverage as required in the bill.
- Requires rental bicycles must also meet all the requirements of ch. 316, F.S.
- Requires bicycle sharing companies register their business with the Division of Corporations and provide such registration to any local governmental entity in whose jurisdiction they operate.
- Requires a bicycle sharing company to secure all their bicycles during hurricane or tropical storm warnings.
- Requires local governmental entities to give a bicycle sharing company 24 hour notice to move an illegally parked bicycle before a fine can be issued.
- Prohibits local governmental entities from passing ordinances that would prohibit a bicycle sharing company from operating within their jurisdiction.
- Clarifies local governmental entities can enforce uniform traffic violations under ch. 316, F.S.

B. Amendments:

None.

891624

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2018	.	
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	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 341.851, Florida Statutes, is created to read:

341.851 Bicycle sharing.—

(1) LEGISLATIVE INTENT.—It is the intent of the Legislature to provide Florida residents with access to innovative, environmentally friendly transportation options and to ensure

the safety and reliability of bicycle sharing services within the state.

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

(a) "Bicycle sharing company" means a person who makes bicycles, as defined in s. 316.003(3), available for private use by reservation through an online application, software, or website.

(b) "Docking station" means a bicycle rack controlled by a bicycle sharing company where bicycles may be parked.

(c) "Local governmental entity" means a county, municipality, special district, airport authority, port authority, or other local governmental entity or subdivision.

(d) "User" means a person at least 18 years of age who reserves a bicycle through a bicycle sharing company's online application, software, or website.

(3) MINORS.—A bicycle sharing company may allow a minor to operate a bicycle reserved by a user if accompanied by a user. Such a minor operator who is under the age of 16 must wear a helmet as required in s. 316.2065(3)(d).

(4) INSURANCE REQUIRED.—

(a) A person may not operate a bicycle sharing company in this state pursuant to this section unless the person maintains a current and valid combined single-limit policy of commercial general liability insurance coverage in the amount of at least $500,000 per occurrence for bodily injury and property damage.

(b) A local governmental entity may annually require a bicycle sharing company to provide proof of insurance meeting the requirements of this subsection. If a bicycle sharing company does not provide proof of such insurance, the local

governmental entity may issue a fine no greater than $5,000 and may order the bicycle sharing company to cease and desist from operating within the local governmental entity's jurisdiction until any such fine is paid and proof of such insurance is provided.

(5) BICYCLE REQUIREMENTS.—Each bicycle made available for reservation by a bicycle sharing company must:

(a) Meet the requirements for bicycles set forth in 16 C.F.R. part 1512 and s. 316.2065.

(b) Prominently display the bicycle company's trade dress.

(c) Display an e-mail address or a telephone number at which a user or operator may contact the bicycle sharing company for customer support.

(d) Be lawfully parked when not in use.

(6) COMPANY RESPONSIBILITIES.—

(a) A bicycle sharing company must register with the Division of Corporations of the Department of State and must provide such registration to any local governmental entity in whose jurisdiction the company operates. A local governmental entity may issue a bicycle sharing company a fine no greater than $1,000 for failure to comply with this paragraph.

(b) A bicycle sharing company must provide to users through its online application, software, or website:

1. Notification that bicycles must be operated in compliance with state and local law.

2. An interface that enables a user to notify the bicycle sharing company of an issue relating to the safety or maintenance of a bicycle.

(c) A bicycle sharing company is responsible for the

maintenance and rebalancing of each bicycle made available for reservation and for the removal of any such bicycle that is for any reason inoperable or does not comply with subsection (5).

(d) A bicycle sharing company is responsible for securing all company bicycles located within any area of the state where an active tropical storm or hurricane warning has been issued. A local governmental entity may issue a bicycle sharing company a fine no greater than $1,000 for failure to comply with this paragraph.

(e) A bicycle sharing company must comply with the requirement of s. 316.2065(15)(a) when allowing a minor operator under the age of 16.

(7) PREEMPTION.—

(a) It is the intent of the Legislature to provide for uniformity of laws governing bicycle sharing companies throughout the state. Bicycle sharing companies meeting the requirements of this section shall be governed exclusively by state law and a local governmental entity may not:

1. Impose a tax on, or require a license for, a bicycle sharing company relating to reserving a bicycle;

2. Subject a bicycle sharing company to any rate, entry, operation, or other requirement of the local governmental entity;

3. Except as provided in subsection (6), require a bicycle sharing company to obtain a business license or any other type of authorization to operate within the jurisdiction of the local governmental entity; or

4. Except as provided in subsection (4), prohibit a bicycle sharing company from operating within the jurisdiction of the

891624

local governmental entity or limit the operation of a bicycle sharing company within such jurisdiction.

(b) This subsection does not prohibit:

1. An airport or seaport from designating locations for staging, pickup, and other similar operations relating to bicycles at the airport or seaport;

2. A local governmental entity from entering into agreements with bicycle sharing companies for the placement of docking stations on public land; or

3. A local governmental entity from enforcing uniform traffic infractions under chapter 316.

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

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to bicycle sharing; creating s. 341.851, F.S.; providing legislative intent; defining terms; authorizing a bicycle sharing company to allow a minor to operate a bicycle reserved by a user if accompanied by a user; requiring such a minor operator who is under a specified age to wear a helmet; providing insurance requirements for a bicycle sharing company; authorizing a local governmental entity to annually require a bicycle sharing company to provide proof of insurance; authorizing the local governmental entity to issue a fine no greater than a specified

amount and to order the bicycle sharing company to cease and desist from operating within the local governmental entity's jurisdiction until any such fine is paid and proof of such insurance is provided, if the company does not provide proof of such insurance; providing requirements for bicycles made available for reservation by a bicycle sharing company; providing company responsibilities; authorizing a local governmental entity to issue a bicycle sharing company a fine no greater than a specified amount for failure to comply with specified responsibilities; providing for preemption; providing construction; providing an effective date.

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2018	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (891624) (with title amendment)

Delete lines 81 - 99
and insert:
(f) A bicycle sharing company must remove an unlawfully parked company bicycle within 24 hours of receiving notification of the violation via e-mail from a local governmental entity. Such notice must include the location and identification number of the company bicycle. A local governmental entity may

567094

immediately move an unlawfully parked company bicycle and place it in the nearest location where it does not obstruct or endanger the safe movement of pedestrians or vehicles. For any company bicycle that remains unlawfully parked and is not removed by a bicycle sharing company within the 24-hour period, a local governmental entity may impose a fee of up to $10 per bicycle, per day, not to exceed a total fee of $100 per bicycle. If a bicycle sharing company has not removed an unlawfully parked bicycle within 10 days of receiving notice in accordance with this section, the local governmental entity may impound the bicycle in accordance with local ordinances.

(7) PREEMPTION.—

(a) A local governmental entity may not take any action or adopt any local ordinance, policy, or regulation that is designed to limit or prevent a bicycle sharing company or any company engaged in the rental of bicycles from operating within its jurisdiction, provided that the company has demonstrated compliance with all local laws and regulations applicable to other similar businesses seeking to do business or presently doing business within that jurisdiction.

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

And the title is amended as follows:

Delete lines 136 - 138

and insert:

certain fines and fees and to impose other penalties under certain circumstances; prohibiting a local governmental entity, under certain circumstances, from taking any action or adopting any local ordinance,

567094

policy, or regulation that is designed to limit or prevent a bicycle sharing company or any company engaged in the rental of bicycles from operating within its jurisdiction; providing construction; providing an

By Senator Young

18-01420B-18 20181304__

A bill to be entitled

An act relating to dockless bicycle sharing; creating s. 341.851, F.S.; providing legislative intent; providing definitions; providing insurance requirements for a bicycle sharing company; providing requirements for dockless bicycles made available for reservation by such company; providing company responsibilities; providing for preemption; providing construction; providing an effective date.

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

Section 1. Section 341.851, Florida Statutes, is created to read:

341.851 Dockless bicycle sharing.—

(1) LEGISLATIVE INTENT.—It is the intent of the Legislature to provide Florida residents with access to innovative, environmentally friendly transportation options and to ensure the safety and reliability of bicycle sharing services within the state.

(2) DEFINITIONS.—As used in this section:

(a) "Bicycle sharing company" means an entity that makes dockless bicycles available for private use by reservation through an online application, software, or website.

(b) "Dockless bicycle" means a bicycle, including an electric bicycle, that is self-locking and that is not connected to a docking station.

(c) "Local governmental entity" means a county, municipality, special district, airport authority, port

18-01420B-18 20181304__

authority, or other local governmental entity or subdivision.

(d) "User" means a person who reserves a dockless bicycle through a bicycle sharing company's online application, software, or website.

(3) INSURANCE REQUIRED.—A person or entity may not operate a bicycle sharing company in this state unless the person or entity maintains a current and valid combined single-limit policy of commercial general liability insurance coverage in the amount of at least $500,000 per occurrence for bodily injury and property damage.

(4) BICYCLE REQUIREMENTS.—Each dockless bicycle made available for reservation by a bicycle sharing company must:

(a) Meet the requirements for bicycles set forth in 16 C.F.R. part 1512.

(b) Be available for reservation 24 hours a day, 7 days a week.

(c) Prominently display the bicycle company's trade dress.

(d) Display an e-mail address or a telephone number at which a user may contact the bicycle sharing company for customer support.

(e) Be lawfully parked when not in use.

(5) COMPANY RESPONSIBILITIES.—

(a) A bicycle sharing company must provide through its online application, software, or website:

1. Notification that a rider of a dockless bicycle must operate the dockless bicycle in compliance with state and local law.

2. An interface that enables a user to notify the bicycle sharing company of an issue relating to the safety or

maintenance of a dockless bicycle.

(b) A bicycle sharing company is responsible for the maintenance and rebalancing of each dockless bicycle made available for reservation and for the removal of any such dockless bicycle that is for any reason inoperable.

(6) PREEMPTION.—

(a) It is the intent of the Legislature to provide for uniformity of laws governing dockless bicycles and bicycle sharing companies throughout the state. Dockless bicycles and bicycle sharing companies shall be governed exclusively by state law. A local governmental entity may not:

1. Impose a tax on, or require a license for, a dockless bicycle or a bicycle sharing company relating to reserving a dockless bicycle;

2. Subject a dockless bicycle or a bicycle sharing company to any rate, entry, operation, or other requirement of the local governmental entity;

3. Require a bicycle sharing company to obtain a business license or any other type of authorization to operate within the jurisdiction of the local governmental entity; or

4. Enter into a private agreement containing a provision that prohibits a bicycle sharing company from operating within the jurisdiction of the local governmental entity or that limits the operation of a bicycle sharing company within such jurisdiction. To the extent that a local governmental entity entered into an agreement containing such a provision before July 1, 2018, such provision is unenforceable.

(b) This subsection does not prohibit an airport or seaport from designating locations for staging, pickup, and other

similar operations relating to dockless bicycles at the airport or seaport.

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Health Policy, *Chair*
Appropriations Subcommittee on Pre-K - 12 Education, *Vice Chair*
Commerce and Tourism
Communications, Energy, and Public Utilities
Regulated Industries

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR DANA YOUNG
18th District

January 11, 2018

Senator Anitere Flores, Chair
Banking and Insurance Committee
320 Knott Building
404 S. Monroe Street
Tallahassee, Florida 32399-1100

Dear Chair Flores,

My Senate Bill 1304 regarding Dockless Bicycle Sharing has been referred to your committee. I respectfully request that this bill be placed on your next available agenda.

If you have any questions, please do not hesitate to reach out to me.

Sincerely,

Dana Young
State Senator – 18th District

cc: James Knudson, Staff Director – Banking and Insurance Committee

REPLY TO:
❒ 1211 N. Westshore Blvd, Suite 409, Tampa, Florida 33607 (813) 281-5507
❒ 316 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5018

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

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

1304
Bill Number (if applicable)

Topic Dockless Bicycle Sharing

Amendment Barcode (if applicable)

Name Susan Harbin Alford

Job Title Sr. Associate Director, Public Policy

Address _____ Phone 770 546 8845
Street

Email sharbin@fl-counties.com
City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Association of Counties

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-6-18
Meeting Date

1304
Bill Number (if applicable)

Topic Dockless Bikes

Amendment Barcode (if applicable)

Name Emily Buckley

Job Title Gov't Relations Manager

Address 215 S Monroe St
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850 425 7800

Email ebuckley@joneswalker.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Palm Beach Co

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

1304
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Dockless Bicycle Sharing

Name Brewster Bevis

Job Title Senior Vice President

Address 516 N Adams St
Street

Phone 224-7173

Tallahassee FL 32301
City *State* *Zip*

Email bbevis@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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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

SB 1304
Bill Number (if applicable)

Topic Bike Sharing

Amendment Barcode (if applicable)

Name Dustin Brighton

Job Title Policy Lead - Southeast - Ofo

Address 80 M Street
Street

Phone

Washington D.C.
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Ofo

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

02/6/18
Meeting Date

1304
Bill Number (if applicable)

891624
Amendment Barcode (if applicable)

Topic Dockless Bicycles

Name Jennifer Wilson

Job Title Attorney / Lobbyist

Address 101 E. Kennedy Blvd., Suite 4000
Street

Phone 813-407-0703

Tampa FL 33602
City *State* *Zip*

Email Jennifer.wilson@arlaw.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing North American Bikeshare Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/2018
Meeting Date

1304
Bill Number (if applicable)

567094
Amendment Barcode (if applicable)

Topic Dockless Bicycle Bill

Name Jeff Branch

Job Title Legislative Advocate

Address Bronough St.
Street

Phone

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Florida League of Cities

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2.6.18
Meeting Date

SB 1304
Bill Number (if applicable)

Topic Bike Share

567094
Amendment Barcode (if applicable)

Name Chris Moya

Job Title Director ~~Jones~~ Jones Walker

Address _____ Phone 850.321.6692
Street

_____ Email cmoya@JonesWalker.com
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Decobike & Cyclehop

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Feb. 7. 18
Meeting Date

1304
Bill Number (if applicable)

567094
Amendment Barcode (if applicable)

Topic Bike SHARE

Name JR HARDING

Job Title Co chair FAAST

Address _____ Phone 850. 510. 4628
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

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

Representing FAAST Florida Alliance Assisted Services & technology

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	CS/SB 1422
INTRODUCER:	Banking and Insurance Committee and Senator Rouson
SUBJECT:	Insurance Coverage Parity for Mental Health and Substance Use Disorders
DATE:	February 7, 2018 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1422 codifies the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related regulations, which will provide the Office of Insurance Regulation (OIR) with the authority to ensure that individual and group policies and contracts of health insurers and health maintenance organizations are complying with these provisions. Generally, the MHPAEA requires benefits for mental health and substance use disorders to be in parity with medical and surgical benefits, as it relates to financial requirements, treatment limitations, in-network and out-of-network coverage, and annual and aggregate lifetime limits for applicable policies or contracts that provide mental health benefits.

The bill also requires health insurers and health maintenance organizations (HMOs) to submit an annual report to the OIR demonstrating their compliance with MHPAEA. Medicaid managed care plans are required to submit an annual report to the Agency for Health Care Administration. The OIR is required to submit an annual report to the Legislature describing its methodology for verifying compliance with the MHPAEA.

II. Present Situation:

In 2016, there were 5,725 opioid-related deaths reported in Florida, which is a 35 percent increase from 2015.[1] Deaths caused by fentanyl increased by 97 percent in 2016. Occurrences of cocaine use increased by 57 percent and deaths caused by cocaine increased by 83 percent. In the United States, approximately 7.9 million adults had co-occurring disorders, which is the existence of both a mental health and a substance use disorder.[2]

Federal Mental Health Parity Laws

Commercial Plans

Prior to 1996, health insurance coverage for mental illness was generally not as generous as the coverage for medical and surgical benefits. In response, the Mental Health Parity Act[3] (MHPA) was enacted in 1996, which requires parity of medical and surgical benefits with mental health benefits for annual and aggregate lifetime limits of large group plans.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act[4] (MHPAEA), which generally applies to large group health plans.[5] The MHPAEA expanded parity of coverage to include financial requirements, treatment limitations, and in- and out-of-network coverage if a plan provided coverage for mental illness. The MHPAEA also applies to the treatment of substance use disorders.[6] Like the MHPA, the MHPAEA does not require large groups to provide benefits for mental health or substance use disorders. The MHPAEA contains a cost exemption, which allows a group health plan to receive a waiver, exempting them from some of the key requirements, if the plan demonstrates that costs increased at least 1 percent because of compliance.[7]

In 2010, the Patient Protection and Affordable Care Act[8] (PPACA) amended the MHPAEA to apply the provisions to individual health insurance coverage. The PPACA mandates that qualified health insurance must provide coverage of 10 essential health benefits,[9] including coverage for mental health and substance use disorders for individual and small group qualified health plans. The final rule, implementing these provisions, generally requires health insurers

---

[1] Florida Medical Examiners Commission, *2016 Medical Examiners Commission Drug Report* (Nov. 2017), available at http://www.fadaa.org/resource_center/documents/2016AnnualDrugReport.pdf (last viewed Jan. 31, 2018).
[2] Substance Abuse and Mental Health Services Administration, *Co-occurring* Disorders, available at https://www.samhsa.gov/disorders/co-occurring (last viewed Jan. 31, 2018).
[3] Pub. L. No. 104-204.
[4] Pub. L. No. 110-343.
[5] See final regulations available at http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf (last viewed Jan. 31, 2018).
[6] 45 CFR ss. 146 and 160.
[7] Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least 2 percent in the first year that MHPAEA applies to the plan or coverage or at least 1 percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. If such a cost is incurred, the plan or coverage is exempt from MHPAEA requirements for the plan or policy year following the year the cost was incurred. The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last 1 year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least 1 percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year.
[8] Pub. L. No.111-148, as amended by Pub. L. No. 111-152.
[9] 45 CFR s. 156.115.

offering health insurance coverage in the individual and small group markets to comply with the requirements of the MHPAEA regulations in order to satisfy the essential health benefit requirement.[10]

Medicaid and CHIP Programs

In March 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on mental health parity for Medicaid and the Children's Health Insurance Program (CHIP).[11] The agency amended the Statewide Medicaid Managed Care (SMMC) contract to require Medicaid managed care organizations (MCOs) to comply with the mental health parity requirements no later than October 2, 2017.[12]

The CMS rule requires the Medicaid MCOs to comply with requirements for aggregate lifetime and annual dollar limits that apply to MCOs in states that cover both medical and surgical benefits and mental health or substance use disorder benefits under the Medicaid State Plan. In addition, Medicaid MCOs must comply with requirements for non-quantitative treatment limitations and must make available upon request the medical necessity criteria used for mental health or substance use disorder medical necessity determinations and the reason for denials of reimbursement for mental health or substance use disorder benefits.

The rule also requires, in instances the full scope of medical and surgical and mental health and substance use disorder services are not provided through the MCO, the state must review the mental health and substance use disorder services provided through the MCO and fee-for-service coverage to ensure that the full scope of services available to all enrollees of the MCO complies with the rule. According to the agency, this requirement does not apply to the Florida Medicaid program, as Medicaid has not created a behavioral health services "carve-out" and MCOs offer the full scope of behavioral health services.[13] The rule requires the state to ensure that all services are delivered to the enrollees of the MCO in compliance with the parity requirements. The agency is responsible for ensuring Medicaid MCOs' compliance with Medicaid managed care contracts. Generally under the MHPAEA final rule, the state is required to determine whether the overall Medicaid and CHIP delivery system is compliant with mental health and substance use disorder parity requirements. The MCOs are required to complete a parity analysis and inform the state of changes needed to the MCO contract.

President's Commission on Combating Drug Addiction and the Opioid Crisis

According to the President's Commission on Combating Drug Addiction and the Opioid Crisis, the MHPAEA has been the impetus for much progress towards parity for behavioral health coverage. Plans and employers have largely eliminated policies that are noncompliant, such as policies containing provisions such as dollar-limits, visit limits, and prohibitions on certain treatment modalities that exist only on behavioral health benefits. The report noted the remaining noncompliance is harder for regulators to discern, such as, non-quantitative treatment limits

[10] *See* 45 CFR 147.150 and 156.115 (78 FR 12834, Feb. 25, 2013).
[11] See 42 CFR 438, Subpart K – Parity in Mental Health and Substance Use Disorder Benefits.
[12] See Medicaid health plan contract Attachment II, Section XII.A.
[13] Agency for Health Care Administration, *Analysis of SB 1422* (Jan. 20, 2018) (on file with Senate Committee on Banking and Insurance).

(NQTLs).[14] These hurdles include medical necessity reviews that are more stringent on the behavioral health side than the medical or surgical side, limited provider networks, and onerous prior-authorization requirements. Further, it is often difficult to discern when a behavioral health benefit is on par with a medical/surgical benefit as different care settings and diagnoses have different policies regarding benefits, providers, and authorizations.[15] The Commission recommended that federal and state regulators should use a standardized tool that requires health plans to document and disclose their compliance strategies for non-quantitative treatment limitations (NQTL) parity.[16]

The Office of Insurance Regulation

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[17] 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.[18] 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.[19]

The OIR reviews health insurance policies and contracts for compliance with MHPAEA. The OIR communicates any violations of MHPAEA to the insurer or HMO. If the insurer or HMO fails to correct the issue, the OIR would refer the issue to the appropriate federal regulator as a possible violation of federal law. According to the OIR, no referrals to the federal regulator relating to noncompliance have been required.[20]

Coverage for Mental and Nervous Disorders

Section 627.668, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for mental and nervous disorders for an appropriate additional premium that would include benefits delineated in this section.

Coverage for Substance Abuse

Section 627.669, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for substance abuse that would include benefits listed in the section.

---

[14] Centers for Medicare and Medicaid, Frequently Asked Questions, Mental Health and Substance Use Disorder Parity Implementation (Oct. 27, 2016). See https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-part-34_10-26-16_FINAL.PDF (last viewed Jan. 31, 2018).
[15] The President's Commission on Combating Drugs Addiction and the Opioid Crisis (Nov. 2017), available at http://www.fadaa.org/resource_center/documents/Opioid%20Commission%20Final%20Report%20-%20November%201%202017.pdf (last viewed Jan. 31, 2018).
[16] *Id*.
[17] Section 20.121(3)(a), F.S.
[18] Section 641.21(1), F.S.
[19] Section 641.495, F.S.
[20] Office of Insurance Regulation, *Analysis of SB 1422* (Dec. 12, 2017) (on file with Senate Banking and Insurance Committee).

Agency for Health Care Administration

The Agency for Health Care Administration (agency) is the state agency responsible for administration of the Medicaid program in Florida. Medicaid is a jointly funded program between the state and the federal government. In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the agency under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) program. The agency contracted with managed care plans on a regional basis to provide services to eligible recipients. The benefit package offered by the MMA plans is comprehensive and covers all state plan benefits including mental health and substance abuse treatment services. Full implementation of the MMA program occurred in August 2014.
The agency conducted a review[21] of Florida Medicaid fee-for-service policy and practices relating to mental health and substance use disorder services and determined that Florida's robust behavioral health benefit complies with the quantitative limits. With regard to the non-quantitative limits, one area was identified in the provider network standards section of the SMMC contract, namely, ratios for network adequacy standards for psychiatrists versus primary care physicians. The agency amended the Medicaid MCO contracts to ensure the contracts aligned with parity requirements.

The current SMMC contract contains a requirement that the MCOs must comply with the federal rule, including any non-quantitative limits that the MCOs may impose through their credentialing, authorization, contracting, provider reimbursement, standards for accessing out-of-network providers, or other practices. To assist the MCOs in their efforts to achieve compliance, the state has directed the MCOs to the reference materials provided by CMS in the Parity Compliance Toolkit and Implementation Roadmap, which are publically available on the CMS website.[22] The agency has several existing avenues for monitoring MCOs' compliance with parity, including, but not limited to, the review of new or revised MCO policies and procedures (including utilization management), monitoring of provider and recipient complaints submitted to the Medicaid Complaint Operations Center, and monthly submission to the agency by the MCOs of complaint, grievance, and appeals reporting.

III. Effect of Proposed Changes:

Section 1 amends s. 409.967, F.S., relating to Medicaid managed care plan accountability. This section creates an annual analysis of mental health parity and reporting requirement for Medicaid MCOs, regarding mental health parity. The MCOs are required to submit the report to the agency no later than July 1, and the report must contain the following information:

- A description of the process used to develop or select the medical necessity criteria for mental or nervous disorder benefits, substance use disorder benefits, and medical and surgical benefits;
- Identification of all non-quantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits; and

[21] *Id.*
[22] See CMS, *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, (Jan. 17, 2017) available at https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf (last viewed Jan. 31, 2018).

- The results of an analysis. The analysis must demonstrate that for the medical necessity criteria described above and for each NQTL, the analysis identifies the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the factors used to apply the criteria and NQTLs to medical and surgical benefits. It also establishes minimum criteria to be contained in the analysis. The analysis must include specific findings and conclusions reached by the MCO that the results of the analysis indicates that MCO is in compliance with this section and MHPAEA, any federal guidance or regulations relating to MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

Section 2 amends s. 627.6675, F.S., relating to conversion policies, to provide a technical, conforming cross-references.

Section 3 transfers the provisions of s. 627.668, F.S., relating to optional coverage for mental and nervous disorders, to newly created s. 627.4193, F.S., and amends the section. The section provides that coverage for mental and nervous disorders, including substance use disorders, provided by individual and group policies or contracts may not be less favorable than for physical illness in accordance with parity requirements of 45 C.F.R. s. 136(c)(2) and (3). The section also eliminates the requirement that insurers make available optional coverage for mental and nervous disorders.

The section requires every insurer, HMO, and nonprofit hospital and medical service plan corporation, which transacts individual or group health insurance or providing prepaid health care in Florida, to submit an annual report to the OIR, on or before July 1 of each year. The section requires the OIR to enforce the MHPAEA , any federal guidance or regulations relating to MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

The OIR is required to implement and enforce the applicable provisions of MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3), and this section, which includes performing market conduct examinations to determine compliance and responding to consumer complaints regarding possible violations.

Finally, the section requires the OIR to issue an annual report to the Legislature no later than December 31 of each year, which describes the methodology the OIR uses to verify compliance with MHPAEA, and to post the report on the OIR's website for public access.

Section 4 repeals s. 627.669, F.S, relating to optional coverage for substance use disorders.

Section 5 provides the effective date of the bill is July 1, 2018.

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 new reporting requirement will have an indeterminate fiscal impact on the Medicaid managed care plans and commercial health insurers and health maintenance organizations.

The bill will provide policyholders and subscribers with additional protections for the resolution of coverage issues relating to mental health and substance use disorders parity.

C. Government Sector Impact:

Agency for Health Care Administration. There is no fiscal impact on the Florida Medicaid program.

Office of Insurance Regulation. The OIR would need the 1 FTE Financial Specialist $69,414 (Salary, Benefits, & Standard Expense Package for new FTE) to implement the provisions of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967, 627.6675, and 627.668.

This bill creates section 627.4193 of the Florida Statutes.

This bill repeals section 627.669 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on February 6, 2018:
The CS provides technical and conforming changes.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2018	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 96 - 304

and insert:

2008 (MHPAEA), and any federal guidance or regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

Section 2. Paragraph (b) of subsection (8) of section 627.6675, Florida Statutes, is amended to read:

627.6675 Conversion on termination of eligibility.—Subject

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to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the office under s. 627.410. An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(8) BENEFITS OFFERED.—

(b) An insurer shall offer the benefits specified in s. 627.4193 ~~s. 627.668 and the benefits specified in s. 627.669~~ if those benefits were provided in the group plan.

Section 3. Section 627.668, Florida Statutes, is


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transferred, renumbered as section 627.4193, Florida Statutes, and amended, to read:

627.4193 ~~627.668~~ Requirements for mental health and substance use disorder benefits; reporting requirements ~~Optional coverage for mental and nervous disorders required; exception~~.—

(1) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state must comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and any regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and must provide ~~shall make available to the policyholder as part of the application, for an appropriate additional premium under a group hospital and medical expense-incurred insurance policy, under a group prepaid health care contract, and under a group hospital and medical service plan contract,~~ the benefits or level of benefits specified in subsection (2) for the necessary care and treatment of mental and nervous disorders, including substance use disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by ~~standard nomenclature of~~ the American Psychiatric Association~~, subject to the right of the applicant for a group policy or contract to select any alternative benefits or level of benefits as may be offered by the insurer, health maintenance organization, or service plan corporation provided that, if alternate inpatient, outpatient, or partial hospitalization benefits are selected, such benefits shall not be less than the~~

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~~level of benefits required under paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c), respectively~~.

(2) Under individual or group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors may ~~shall~~ not be less favorable than for physical illness, in accordance with 45 C.F.R. s. 146.136(c)(2) and (3) ~~generally, except that:~~

~~(a) Inpatient benefits may be limited to not less than 30 days per benefit year as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 days per benefit year, the durational limits, dollar amounts, and coinsurance factors thereto need not be the same as applicable to physical illness generally.~~

~~(b) Outpatient benefits may be limited to $1,000 for consultations with a licensed physician, a psychologist licensed pursuant to chapter 490, a mental health counselor licensed pursuant to chapter 491, a marriage and family therapist licensed pursuant to chapter 491, and a clinical social worker licensed pursuant to chapter 491. If benefits are provided beyond the $1,000 per benefit year, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as applicable to physical illness generally.~~

~~(c) Partial hospitalization benefits shall be provided under the direction of a licensed physician. For purposes of this part, the term "partial hospitalization services" is defined as those services offered by a program that is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state.~~

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~~Alcohol rehabilitation programs accredited by an accrediting organization whose standards incorporate comparable regulations required by this state or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In a given benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are used, the total benefits paid for all such services may not exceed the cost of 30 days after inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond the limits set forth in this paragraph, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.~~

(3) Insurers must maintain strict confidentiality regarding psychiatric and psychotherapeutic records submitted to an insurer for the purpose of reviewing a claim for benefits payable under this section. These records submitted to an insurer are subject to the limitations of s. 456.057, relating to the furnishing of patient records.

(4) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state shall submit an annual report to the office, on or before July 1, which contains all of the following information:

(a) A description of the process used to develop or select the medical necessity criteria for:

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1. Mental or nervous disorder benefits;

2. Substance use disorder benefits; and

3. Medical and surgical benefits.

(b) Identification of all nonquantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits. Within any classification of benefits, there may not be separate NQTLs that apply to mental or nervous disorder and substance use disorder benefits but do not apply to medical and surgical benefits.

(c) The results of an analysis demonstrating that for the medical necessity criteria described in paragraph (a) and for each NQTL identified in paragraph (b), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis must:

1. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

2. Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

3. Identify and describe the methods and analyses used, including the results of the analyses, to determine that the

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processes and strategies used to design each NQTL, as written, for mental or nervous disorder and substance use disorder benefits are comparable to, and no more stringently applied than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits;

4. Identify and describe the methods and analyses used, including the results of the analyses, to determine that processes and strategies used to apply each NQTL, in operation, for mental or nervous disorder and substance use disorder benefits are comparable to and no more stringently applied than the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

5. Disclose the specific findings and conclusions reached by the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation that the results of the analyses indicate that the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation is in compliance with this section; MHPAEA; and any regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

(5) The office shall implement and enforce applicable provisions of MHPAEA and federal guidance or regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3), and this section, which includes:

(a) Ensuring compliance by each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or

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providing prepaid health care in this state.

(b) Detecting violations by any insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state.

(c) Accepting, evaluating, and responding to complaints regarding potential violations.

(d) Reviewing, from consumer complaints, for possible parity violations regarding mental or nervous disorder and substance use disorder coverage.

(e) Performing parity compliance market conduct examinations, which include, but are not limited to, reviews of medical management practices, network adequacy, reimbursement rates, prior authorizations, and geographic restrictions of insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations transacting individual or group health insurance or providing prepaid health care in this state.

(6) No later than December 31 of each year, the office shall issue a report to the Legislature which describes the methodology the office is using to check for compliance with MHPAEA; any federal guidance or regulations that relate to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and this section. The report must be written in nontechnical and readily understandable language and must be made available to the public by posting the report on the office's website and by other means the office finds appropriate.

Section 4. Section 627.669, Florida Statutes, is repealed.

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

And the title is amended as follows:

Delete lines 10 - 31

and insert:

F.S.; conforming a provision to changes made by the act; transferring, renumbering, and amending s. 627.668, F.S.; deleting certain provisions that require insurers, health maintenance organizations, and nonprofit hospital and medical service plan organizations transacting group health insurance or providing prepaid health care to offer specified optional coverage for mental and nervous disorders; requiring such entities transacting individual or group health insurance or providing prepaid health care to comply with specified provisions prohibiting the imposition of less favorable benefit limitations on mental health and substance use disorder benefits than on medical and surgical benefits; revising the standard for defining substance use disorders; requiring such entities to submit a specified annual report relating to parity between such benefits to the Office of Insurance Regulation; requiring the office to implement and enforce specified federal provisions, guidance, and regulations; specifying actions the office must take relating to such implementation and enforcement; requiring the office to issue a specified annual report to the Legislature; repealing s. 627.669, F.S., relating to optional coverage required

for substance abuse impaired persons; providing an effective

By Senator Rouson

19-01110-18 20181422__

A bill to be entitled

An act relating to insurance coverage parity for mental health and substance use disorders; amending s. 409.967, F.S.; requiring contracts between the Agency for Health Care Administration and certain managed care plans to require the plans to submit a specified annual report to the agency relating to parity between mental health and substance use disorder benefits and medical and surgical benefits; amending s. 627.6675, F.S.; conforming a cross-reference; transferring, renumbering, and amending s. 627.668, F.S.; deleting certain provisions that require insurers, health maintenance organizations, and nonprofit hospital and medical service plan organizations transacting group health insurance or providing prepaid health care to offer specified optional coverage for mental and nervous disorders; requiring such entities transacting individual or group health insurance or providing prepaid health care to comply with specified provisions prohibiting the imposition of less favorable benefit limitations on mental health and substance use disorder benefits than on medical and surgical benefits; requiring such entities to submit a specified annual report relating to parity between such benefits to the Office of Insurance Regulation; requiring the office to implement and enforce specified federal provisions, guidance, and regulations; specifying actions the office must take relating to such implementation and enforcement;

19-01110-18 20181422__

requiring the office to issue a specified annual report to the Legislature; providing an effective date.

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

Section 1. Paragraph (p) is added to subsection (2) of section 409.967, Florida Statutes, 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:

(p) *Annual reporting relating to parity in mental health and substance use disorder benefits.*—Every managed care plan shall submit an annual report to the agency, on or before July 1, which contains all of the following information:

1. A description of the process used to develop or select the medical necessity criteria for:

a. Mental or nervous disorder benefits;

b. Substance use disorder benefits; and

c. Medical and surgical benefits.

2. Identification of all nonquantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits. Within any classification of benefits, there may not be separate NQTLs that apply to mental or nervous disorder and substance use disorder benefits but do not apply to medical and surgical benefits.

3. The results of an analysis demonstrating that for the medical necessity criteria described in subparagraph 1. and for each NQTL identified in subparagraph 2., as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis must:

a. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

b. Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

c. Identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each NQTL, as written, for mental or nervous disorder and substance use disorder benefits are comparable to, and no more stringently applied than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits;

d. Identify and describe the methods and analyses used, including the results of the analyses, to determine that processes and strategies used to apply each NQTL, in operation, for mental or nervous disorder and substance use disorder benefits are comparable to, and no more stringently applied

than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

e. Disclose the specific findings and conclusions reached by the managed care plan that the results of the analyses indicate that the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation is in compliance with this section, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); any federal guidance or regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and any other relevant current or future regulations.

Section 2. Paragraph (b) of subsection (8) of section 627.6675, Florida Statutes, is amended to read:

627.6675 Conversion on termination of eligibility.—Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance,

referred to in this section as a "converted policy." A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the office under s. 627.410. An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(8) BENEFITS OFFERED.—

(b) An insurer shall offer the benefits specified in s. 627.4193 ~~s. 627.668~~ and the benefits specified in s. 627.669 if those benefits were provided in the group plan.

Section 3. Section 627.668, Florida Statutes, is transferred, renumbered as section 627.4193, Florida Statutes, and amended, to read:

627.4193 ~~627.668~~ Requirements for mental health and substance use disorder benefits; reporting requirements ~~Optional coverage for mental and nervous disorders required; exception~~.—

(1) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state must comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and any regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and must provide ~~shall make available to the policyholder as~~

~~part of the application, for an appropriate additional premium under a group hospital and medical expense-incurred insurance policy, under a group prepaid health care contract, and under a group hospital and medical service plan contract,~~ the benefits or level of benefits specified in subsection (2) for the necessary care and treatment of mental and nervous disorders, including substance use disorders, as defined in the standard nomenclature of the American Psychiatric Association~~, subject to the right of the applicant for a group policy or contract to select any alternative benefits or level of benefits as may be offered by the insurer, health maintenance organization, or service plan corporation provided that, if alternate inpatient, outpatient, or partial hospitalization benefits are selected, such benefits shall not be less than the level of benefits required under paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c), respectively~~.

(2) Under individual or group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors may ~~shall~~ not be less favorable than for physical illness, in accordance with 45 C.F.R. s. 146.136(c)(2) and (3) ~~generally, except that:~~

~~(a) Inpatient benefits may be limited to not less than 30 days per benefit year as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 days per benefit year, the durational limits, dollar amounts, and coinsurance factors thereto need not be the same as applicable to physical illness generally.~~

~~(b) Outpatient benefits may be limited to $1,000 for~~

~~consultations with a licensed physician, a psychologist licensed pursuant to chapter 490, a mental health counselor licensed pursuant to chapter 491, a marriage and family therapist licensed pursuant to chapter 491, and a clinical social worker licensed pursuant to chapter 491. If benefits are provided beyond the $1,000 per benefit year, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as applicable to physical illness generally.~~

~~(c) Partial hospitalization benefits shall be provided under the direction of a licensed physician. For purposes of this part, the term "partial hospitalization services" is defined as those services offered by a program that is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state. Alcohol rehabilitation programs accredited by an accrediting organization whose standards incorporate comparable regulations required by this state or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In a given benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are used, the total benefits paid for all such services may not exceed the cost of 30 days after inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond the limits set forth in this paragraph, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.~~

(3) Insurers must maintain strict confidentiality regarding psychiatric and psychotherapeutic records submitted to an insurer for the purpose of reviewing a claim for benefits payable under this section. These records submitted to an insurer are subject to the limitations of s. 456.057, relating to the furnishing of patient records.

(4) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state shall submit an annual report to the office, on or before July 1, which contains all of the following information:

(a) A description of the process used to develop or select the medical necessity criteria for:

1. Mental or nervous disorder benefits;

2. Substance use disorder benefits; and

3. Medical and surgical benefits.

(b) Identification of all nonquantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits. Within any classification of benefits, there may not be separate NQTLs that apply to mental or nervous disorder and substance use disorder benefits but do not apply to medical and surgical benefits.

(c) The results of an analysis demonstrating that for the medical necessity criteria described in paragraph (a) and for each NQTL identified in paragraph (b), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or

nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis must:

1. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

2. Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

3. Identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each NQTL, as written, for mental or nervous disorder and substance use disorder benefits are comparable to, and no more stringently applied than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits;

4. Identify and describe the methods and analyses used, including the results of the analyses, to determine that processes and strategies used to apply each NQTL, in operation, for mental or nervous disorder and substance use disorder benefits are comparable to and no more stringently applied than the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

5. Disclose the specific findings and conclusions reached by the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation that the results

of the analyses indicate that the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation is in compliance with this section; MHPAEA; any regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and any other relevant current or future regulations.

(5) The office shall implement and enforce applicable provisions of MHPAEA and federal guidance or regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3), and this section, which includes:

(a) Ensuring compliance by each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state.

(b) Detecting violations by any insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state.

(c) Accepting, evaluating, and responding to complaints regarding potential violations.

(d) Reviewing, from consumer complaints, for possible parity violations regarding mental or nervous disorder and substance use disorder coverage.

(e) Performing parity compliance market conduct examinations, which include, but are not limited to, reviews of medical management practices, network adequacy, reimbursement rates, prior authorizations, and geographic restrictions of

insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations transacting individual or group health insurance or providing prepaid health care in this state.

(6) No later than December 31 of each year, the office shall issue a report to the Legislature which describes the methodology the office is using to check for compliance with MHPAEA; any federal guidance or regulations that relate to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and this section. The report must be written in nontechnical and readily understandable language and must be made available to the public by posting the report on the office's website and by other means the office finds appropriate.

Section 4. This act shall take effect July 1, 2018.

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair

Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 17, 2018

I respectfully request that **Senate Bill #1422**, relating to Insurance Coverage Parity for Mental Health and Substance Use Disorders, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Darryl Rouson
Florida Senate, District 19

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

1422
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Mental Health Insurance Parity

Name Shane Messer

Job Title Legislative affairs director

Address 316 E Park
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850/322-6693

Email Shane@fccmh.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Council for Behavioral Healthcare

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/6/18
Meeting Date

1422
Bill Number (if applicable)

Topic Mental Health Parity

Amendment Barcode (if applicable)

Name Alisa LaPolt

Job Title Executive Director

Address PO Box 961
Street

Phone 850-671-4445

TLH FL 32302
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing National Alliance on Mental Illness

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-6-18
Meeting Date

SB 1422
Bill Number (if applicable)

Topic Insurance Coverage - Parity

Amendment Barcode (if applicable)

Name Mark Fontaine

Job Title CEO

Address 2868 Mahan Drive
Street

Phone 878-2196

Tallahassee FL 32308
City *State* *Zip*

Email mfontaine@fadaa.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Behavioral Health Assoc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR ROB BRADLEY
5th District

COMMITTEES:
Appropriations, *Chair*
Environmental Preservation and Conservation, *Chair*
Appropriations Subcommittee on Higher Education
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Banking and Insurance
Criminal Justice
Judiciary
Rules

JOINT COMMITTEE:
Joint Legislative Budget Commission, *Alternating Chair*

MEMORANDUM

To: Chair Anitere Flores
From: Senator Rob Bradley
Subject: Committee Meeting Absence
Date: February 7, 2018

Due to an unexpected illness, please excuse me from attending the Committee on Banking and Insurance meeting scheduled for February 6, 2018.

Thank you for your consideration.

REPLY TO:
❒ 1279 Kingsley Avenue, Suite 107, Orange Park, Florida 32073 (904) 278-2085
❒ 414 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5005

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

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

CourtSmart Tag Report

Room: EL 110 **Case No.:** **Type:**
Caption: Senate Banking and Insurance Committee **Judge:**

Started: 2/6/2018 11:03:53 AM
Ends: 2/6/2018 12:27:42 PM Length: 01:23:50

11:05:27 AM Meeting called to order. quorum present
11:06:04 AM TAB 4 - S 1126 - Brandes - Licensure of Check Cashers
11:06:18 AM Senator Brandes recognized to present the bill
11:07:09 AM Delete all amd. (228994)
11:07:24 AM Courtney Larkin, FL Office of Financial Regulation
11:09:23 AM Greg Oaks -FL OFR
11:09:32 AM Delete all amend (228994) adopted
11:10:59 AM Senator Brandes to close on bill.
11:11:16 AM Roll call on CS 1126 - Favorable
11:12:26 AM TAB 2 - S 784 Brandes - Insurance
11:12:40 AM Senator Brandes explains the bill.
11:14:22 AM Delete all amd (449152) --
11:15:10 AM Amd. 755264 (Amd. to Amd.) fwo/adopted
11:15:25 AM Amd. 584058 (withdrawn)
11:16:19 AM Amd. to Amd. (909708) Late filed - fwo/adopted
11:16:50 AM Delete all Amd. - fwo - adopted
11:17:30 AM Roll call vote on CS/SB 784 - Favorable
11:18:00 AM Recording Paused
11:23:27 AM Recording Resumed
11:23:30 AM
11:23:58 AM Meeting called back to order.
11:24:59 AM TAB 6 - SB 1422 - Rouson - Insurance Coverage Parity for Mental Health
11:25:09 AM Senator Rouson recognized to present the bill.
11:27:44 AM Late filed Amd. (774792) taken up.
11:28:00 AM Sen. Rouson explains the Amd. (774792)
11:28:27 AM Amendment adopted
11:28:40 AM Senator Rouson recognized to close on bill.
11:29:17 AM Roll call vote on CS/S 1422 - Favorable
11:30:34 AM TAB 5-- S 1304 Young - Dockless Bicycle Sharing
11:31:00 AM Senator Young recognized to explain the bill.
11:40:34 AM Amd. to Amd. 567094 --
11:40:54 AM Chris Moya - Decobike and Cyclehop
11:43:33 AM J.R. Harding
11:44:49 AM Jeff Branch, FL League of Cities
11:47:44 AM Jennifer Wilson, North American Bikeshare Assoc.
11:48:48 AM Amendments adopted
11:49:02 AM Susan Alford
11:50:11 AM Senator Garcia in debate on bill.
11:52:24 AM Senator Gainer in debate
11:52:36 AM Senator Young closes on bill.
11:52:58 AM Roll call vote on CS/s 1304 - Favorable
11:53:45 AM TAB 1 S 662 Stargel - Protection for Vulnerable Investors
11:54:02 AM Sen. Stargel recognized to explain the bill.
11:55:21 AM Courtney Larkin - OFR
11:56:14 AM Warren Husband ---Securities Industry and Financial Markers Assoc.
11:58:31 AM Shannon Miller -- Academy of FL Elder Law Attorneys
11:59:03 AM Sean Stafford, FL Security Dealer Assn.
12:03:35 PM Senator Stargel recognized to close on bill.
12:03:51 PM Roll call vote on S 662 - Favorable
12:04:37 PM TAB 3 - S 1106 by Sen. Bean - Information Used for Insurance
12:06:01 PM Senator Gainer with question for sponsor.
12:06:42 PM Senator Broxson with question.

12:07:01 PM Late filed amd. (780580)
12:07:18 PM Senator Bean recognized to explain late filed amd. -- fwo -- adopted
12:07:47 PM Paul Sanford - FIC - ACLI
12:08:45 PM Bruce Margolis - American Council of Life Insurers
12:12:51 PM Senator Bloxson with question for speaker.
12:18:00 PM Senator Gainer with question for speaker.
12:19:27 PM Senator Garcia with question for speaker.
12:23:00 PM Tom Jobs waives in support of bill.
12:23:17 PM Comments by Senator Broxson.
12:25:34 PM Senator Bean recognized to close on bill.
12:26:09 PM Roll call vote on S 1106 - Favorable
12:27:33 PM Meeting adjourned