Tab 1	**SB 736** by **Diaz**; (Similar to H 00747) Coverage for Air Ambulance Services

198296	A	S	RCS	BI, Diaz	Delete L.23 - 48:	01/21 01:52 PM

Tab 2	**SB 914** by **Brandes**; Property Insurance

806840	A	S	RCS	BI, Brandes	Delete L.17 - 44:	01/21 01:52 PM
232410	T	S	RCS	BI, Brandes	In title, delete L.2:	01/21 01:52 PM

Tab 3	**SB 1006** by **Baxley (CO-INTRODUCERS) Perry, Rouson, Diaz, Flores, Farmer, Braynon, Harrell, Gruters, Book, Hooper, Pizzo**; (Similar to H 00125) Coverage for Hearing Aids for Children

Tab 4	**SB 1224** by **Simmons (CO-INTRODUCERS) Gruters**; (Identical to H 00469) Real Estate Conveyances

Tab 5	**SB 1338** by **Wright (CO-INTRODUCERS) Harrell**; Prescription Drug Coverage

632656	A	S		BI, Lee	Before L.44:	01/21 10:11 AM
275668	A	S		BI, Wright	Delete L.146 - 148:	01/21 11:05 AM
422030	A	S		BI, Thurston	btw L.510 - 511:	01/17 03:47 PM

Tab 6	**SB 1376** by **Broxson**; (Similar to H 01211) Credit For Reinsurance

Tab 7	**SB 1404** by **Perry**; (Similar to H 01077) Department of Financial Services

~~830734~~	A	S	WD	BI, Perry	btw L.325 - 326:	01/21 01:52 PM
765294	A	S	RCS	BI, Perry	btw L.325 - 326:	01/21 01:52 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Tuesday, January 21, 2020
TIME: 12:00 noon—1:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 736** Diaz (Similar H 747)	Coverage for Air Ambulance Services; Requiring health insurers and health maintenance organizations to provide reasonable reimbursement to air ambulance services for certain covered services; providing that such reimbursement may be reduced only by certain amounts; providing that reasonable reimbursement must serve as full and final payment to the air ambulance service, etc. BI 01/21/2020 Fav/CS HP RC	Fav/CS Yeas 8 Nays 0
2	**SB 914** Brandes	Property Insurance; Providing that, for certain attorney fees awarded for claims arising under property insurance policies, the maximum fee a court may award is a lodestar fee; prohibiting the court from considering contingency risk or using a contingency risk multiplier, etc. BI 01/21/2020 Fav/CS JU RC	Fav/CS Yeas 5 Nays 3
3	**SB 1006** Baxley (Similar H 125)	Coverage for Hearing Aids for Children; Requiring certain individual health insurance policies to provide coverage for hearing aids for children 21 years of age or younger; specifying health care providers who may prescribe, fit, and dispense the hearing aids; specifying a minimum coverage limit within a certain timeframe; providing that an insured is responsible for certain costs that exceed the policy limit, etc. BI 01/21/2020 Favorable HP AP	Favorable Yeas 7 Nays 0
4	**SB 1224** Simmons (Identical H 469)	Real Estate Conveyances; Providing that subscribing witnesses are not required to validate certain instruments conveying a leasehold interest in real property, etc. BI 01/21/2020 Favorable JU RC	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	**SB 1338** Wright	Prescription Drug Coverage; Authorizing the Office of Insurance Regulation to examine pharmacy benefit managers; requiring health insurers and health maintenance organizations, or pharmacy benefit managers on behalf of health insurers and health maintenance organizations, to annually report specified information to the office; specifying requirements relating to brand-name and generic drugs in contracts between pharmacy benefit managers and pharmacies or pharmacy services administration organizations, etc. BI 01/21/2020 Not Considered AHS AP	Not Considered
6	**SB 1376** Broxson (Similar H 1211)	Credit For Reinsurance; Adding conditions under which a ceding insurer must be allowed credit for reinsurance; specifying requirements for assuming insurers and reinsurance agreements; authorizing a ceding insurer or its representative that is subject to rehabilitation, liquidation, or conservation to seek a certain court order; authorizing the Office of Insurance Regulation to revoke or suspend an assuming insurer's eligibility under certain conditions, etc. BI 01/21/2020 Favorable JU RC	Favorable Yeas 8 Nays 0
7	**SB 1404** Perry (Similar H 1077)	Department of Financial Services; Specifying powers and duties of the Division of Public Assistance Fraud; prohibiting persons from acting as or advertising themselves as being funeral directors, embalmers, direct disposers, or preneed sales agents unless they are so licensed; revising the definition of the term "two-component explosives" for the purpose of regulation by the Division of State Fire Marshal; providing that certain persons serving as volunteer firefighters may serve as a regular or permanent firefighter for a limited period, subject to certain restrictions, etc. BI 01/21/2020 Fav/CS AEG AP	Fav/CS Yeas 8 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:	CS/SB 736
INTRODUCER:	Banking and Insurance Committee and Senator Diaz
SUBJECT:	Coverage for Air Ambulance Services
DATE:	January 22, 2020 REVISED:

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 736 requires health insurers and health maintenance organizations (HMOs) to provide reasonable reimbursement to air ambulances for covered services. The bill defines the term, "reasonable reimbursement," to mean reimbursement that considers the actual cost of provided services, the operation of an air ambulance service by a county that operates entirely within a designated area of critical state concern, and in-network reimbursement established by the insurer for the specific policy. Reasonable reimbursement may be reduced only by applicable copayments, coinsurance, and deductibles. Such reimbursement must serve as full and final payment to the air ambulance service.

Air ambulances provide emergency services for critically ill patients, primarily in life-threatening situations, regardless of their insurance status or ability to pay. Privately-insured patients who are transported by air ambulance providers that are outside of provider networks of their respective insurer or HMO are at financial risk for balance billing, which is the difference between prices charged by providers and the payment rates established by insurers or HMOs. Any balance billing incurred by a patient is in addition to copayments or other types of cost-sharing typically paid under the insurance policy or HMO contract.

While states can regulate the medical aspects of air ambulances, the federal Airline Deregulation Act of 1979 (ADA)[1] preempts states from economic regulation, i.e., regulating rates, routes, and services of air ambulances.

II. Present Situation:

Emergency medical transportation is a life-saving service that affects all Floridians, including the uninsured, privately insured, and those covered by federal health care programs. According to the National Association of Insurance Commissioners, more than 550,000 patients in the U.S. use air ambulances each year.[2] The average air ambulance trip is 52 miles, and costs $12,000 to $25,000 per flight. The significant price accounts for the initial aircraft cost which can reach $6 million as well as medical equipment and maintenance.[3] Also factoring into the price is the cost of round-the-clock availability for medical personnel and pilots. Contingent on the severity of the medical condition, the number and type of medical staff on board can vary, further influencing the flight price.

Florida Insurance Consumer Advocate's Working Group

The Insurance Consumer Advocate of the Department of Financial Services[4] created the Emergency Medical Transportation (EMT) Working Group in 2016 to assess the impact of EMT costs to Florida's privately-insured consumers, and to make recommendations to address concerns faced by ground and air ambulance services, the insurance industry, state and local governments, and consumers. In 2018, the Insurance Consumer Advocate released a report, which provided extensive background information about the EMT industry, ambulance costs, insurance coverage, and the impact on insureds.[5]

In regards to licensed air emergency medical services providers, the report noted that there are 37 companies. Typically, three types of business models exist for air ambulances providers, namely, hospital-based, independent, and government operator. The air ambulances provide services using a fixed-wing airplane or a rotary-wing helicopter.

Average Bill for Air Emergency Transportation in Florida

FAIR Health[6] provided extensive data to the Insurance Consumer Advocate's report regarding the average bills in Florida. FAIR Health data indicates that the average bill for a fixed-wing airplane transport in Florida was $15,828, while the U.S. 80th percentile was at $22,500. When comparing Florida to other states, Georgia's average charge was $11,661, New York's was

[1] Federal Airline Deregulation Act of 1978. Pub. L. No. 95-504, 92 STAT. 1705.
[2] National Association of Insurance Commissioners, *Understanding Air Ambulance Insurance Coverage* (May 2018) https://www.naic.org/documents/consumer_alert_understanding_air_ambulance_insurance.htm (last viewed Jan. 13, 2020).
[3] *Id.*
[4] The Florida Insurance Commissioner created the Office of the Insurance Consumer Advocate in 1990. In 1992, the Legislature codified the office under s. 627.0613, F.S.
[5] Insurance Consumer Advocate, *Emergency Medical Transportation Costs in Florida* (May 2018) at https://www.myfloridacfo.com/Division/ICA/EMTWhitePaper.pdf (last viewed Jan. 13, 2020). The data is indicative of information for the period of October 1, 2015 through September 30, 2016.
[6] FAIR Health is an independent nonprofit that collects data for and manages the nation's largest database of privately billed health insurance claims, including Medicare Parts A, B and D claims data for 2013 to the present. *See* https://www.fairhealth.org/about-us (last viewed Jan. 16, 2020).

$17,226, and Texas' was $18,238. Comparatively speaking, Florida has a lower average charge than New York and Texas, but Florida's average charge was more than $4,000 higher than Georgia's average charge for a fixed-wing transport.

In the report, FAIR Health noted that the average bill for a rotary-wing helicopter transport in Florida was $21,221. As with fixed-wing, this is also below the U.S. 80th percentile of $29,036. While Georgia had the lowest average charge for fixed-wing transport of the states analyzed, Florida holds the lowest average charge for rotary-wing transport. Georgia's average charge for rotary-wing transport was $24,660, New York's was $25,857, and Texas was $22,652.

Recommendations of the Insurance Consumer Advocate

The report included the following recommendations:

1. Steps must be taken to deregulate the aeromedical industry from federal regulation so that states may regulate the market to address consumer concerns.
2. Consumers should have increased access to in-network EMT providers in order to decrease the likelihood of surprise medical bills.
3. The current billing model used for ground EMT should be revised to allow ambulance companies to charge for medical services and treatments without the requirement of transporting the patient to a medical facility.
4. Stakeholders should commit to improving transparency and consumer education.

Federal Laws Relating to Air Ambulance Billing

The authority of states to address issues related to air ambulance balance billing is affected by the following federal laws:

- **Airline Deregulation Act of 1978 (ADA).** A provision in this law preempts state-level economic regulation—i.e., regulating rates, routes, and services—of air carriers authorized by United States' Department of Transportation (DOT) to provide air transportation.[7] In general, courts have held that air ambulances are considered air carriers under the ADA's preemption provision. The courts, the DOT, and state attorneys general have determined specific issues related to the air ambulance industry that cannot be regulated at the state level having a connection with or reference to a carrier's rates, routes, or services.[8]

- **McCarran-Ferguson Act of 1945.** This act affirms that states have the authority to regulate the business of insurance.[9] For example, states may review insurers' health insurance plans and premium rates. In instances of balance billing, states can determine whether the insurer paid a provider in accordance with its policy for paying for out-of-network services.

- **Employee Retirement Income Security Act of 1974 (ERISA).** The ERISA provides a federal framework for regulating employer-based pension and welfare benefit plans, including health plans.[10] Although states may regulate health insurers, the ERISA

[7] Pub. L. No. 95-504, s. 4, 92 Stat. 1705, 1707 (codified as revised and amended at 49 U.S.C. s. 41713(b)).
[8] General Accounting Office, *Air Ambulances: Available Data Show Privately-Insured Patients Are at Financial Risk* (Mar. 20, 2019) at https://www.gao.gov/products/GAO-19-292 (last viewed Jan. 11, 2020).
[9] Act of Mar. 9, 1945, Ch. 20, s. 2, 59 Stat. 33, 34 (codified as amended at 15 U.S.C. s. 1012).
[10] *See*, Pub. L. No. 93-406, 88 Stat. 646 (codified as amended at 29 U.S.C. ss. 1001 et seq.).

preemption generally prevents states from directly regulating self-insured employer-based health plans.

- **The Patient Protection and Affordable Care Act**, provides limited balance billing protections[11] for insureds or subscribers who receive ambulance services from an out-of-network provider.[12] In the case of air ambulances, these protections are only applied when the service is affiliated with a hospital and thus considered an extension of the emergency department service.[13]

State Laws Relating to Emergency Services and Insurance Coverage

Access to Emergency Services and Care

In 1986, Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. The EMTALA imposes specific obligations on hospitals participating in the Medicare program, which offer emergency services. Any patient who comes to the emergency department must be provided with a medical screening examination to determine if the patient has an emergency medical condition. If an emergency medical condition exists, the hospital must provide treatment within its service capability to stabilize the patient. If a hospital is unable to stabilize a patient or, if the patient requests, the hospital must transfer the patient to another appropriate facility.[14] A hospital that violates EMTALA is subject to civil monetary penalty[15] or civil suit by a patient who suffers personal harm.[16]

Florida law imposes a similar duty.[17] The law requires the Agency for Health Care Administration to maintain an inventory of the service capability of all licensed hospitals that provide emergency care in order to assist emergency medical services (EMS or ambulance) providers and the public in locating appropriate medical care. Hospitals must provide all listed services when requested, whether by a patient, an emergency medical services provider, or another hospital, regardless of the patient's ability to pay. If the hospital is at capacity or does not provide the requested emergency service, the hospital may transfer the patient to the nearest facility with appropriate available services. Each hospital must ensure the services listed can be provided at all times either directly or through another hospital. A hospital is prohibited from basing emergency treatment and care on a patient's insurance status, economic status, or ability to pay. A hospital that violates Florida's access to care statute is subject to administrative

[11] The regulations establish minimum payment standards for insurers and HMOs. However, insurers or HMOs are not required to cover amounts that out-of-network providers may "balance bill." *See* 80 FR 72192.
[12] The Patient Protection and Affordable Care Act (Pub. L. 111–148), was enacted on March 23, 2010; the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was enacted on March 30, 2010. These statutes are collectively referred to as "PPACA."
[13] National Association of Insurance Commissioners, *Air Ambulance Regulation*, (Jan. 2019) at https://www.naic.org/documents/government_relations_air_ambulance_regulation_issue_brief.pdf (last viewed Jan. 14, 2020).
[14] Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §1395dd; *see also* CENTERS FOR MEDICARE & MEDICAID SERVICES, *Emergency Medical Treatment & Labor Act (EMTALA)*, http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/ (last visited Jan. 13, 2020).
[15] 42 U.S.C. s. 1395dd(d)(1).
[16] 42 U.S.C. s. 1395dd(d)(2).
[17] *See* s. 395.1041, F.S.

penalties; denial, revocation, or suspension of its license; or civil action by another hospital or physician suffering financial loss. In addition, hospital administrative or medical staff are subject to civil suit by a patient who suffers personal harm, and may be found guilty of a second-degree misdemeanor for a knowing or intentional violation. Physicians who violate the act are also subject to disciplinary action against their license or civil action by another hospital or physician suffering financial loss.

Regulation of Emergency Medical Transportation

Part III of ch. 401, F.S., governs the provision of emergency medical transportation services in Florida, and establishes the licensure and operational requirements for emergency medical services, including air ambulances.[18] Air ambulance service refers to a licensed publicly or privately owned service that operates air ambulances to transport persons requiring or likely to require medical attention during transport.[19] An air ambulance is a fixed-wing or rotary-wing aircraft used for, or intended to be used for, the air transportation of sick or injured persons that require or are likely to require medical attention during transport.[20]

Regulation of Insurance

The Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities.[21] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[22] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[23] As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[24]

Federal Reports Relating to Air Ambulance Costs

A 2017 General Accounting Office (GAO) report noted that, between 2010 and 2014, the national median prices providers charged for helicopter-air ambulance service approximately doubled, from around $15,000 to about $30,000 per transport.[25] In 2017, the median price charged nationally by air ambulance providers was about $36,400 for helicopter transportation and $40,600 for a fixed wing transport.[26] The total generally includes the costs for both the transportation and the medical care aboard the aircraft. Air ambulance providers may not turn away patients based on their ability to pay. The providers receive payments from many sources depending on the patient's coverage, often at rates lower than the price charged.

[18] Section 401.251, F.S.
[19] Section 401.23, F.S.
[20] *Id.*
[21] Section 20.121(3)(a)1., F.S.
[22] Section 641.21(1), F.S.
[23] Sections 624.401 and 641.49, F.S.
[24] Section 641.495, F.S.
[25] General Accounting Office, *Data Collection and Transparency Needed to Enhance DOT Oversight* (GAO-17-637) (Jul. 2017) at https://www.gao.gov/assets/690/686167.pdf (last viewed Jan. 13, 2020).
[26] General Accounting Office, *Air Ambulances: Available Data Show Privately-Insured Patients Are at Financial Risk* (Mar. 20, 2019) at https://www.gao.gov/products/GAO-19-292 (last viewed Jan. 11, 2020).

Selected providers reported that factors such as transport costs and volume, payer mix, and competition play a role in prices charged. Air ambulance providers' costs for air ambulance service are relatively fixed—meaning they do not increase significantly when they complete more transports. For example, personnel and the costs of helicopter ownership are the same regardless of how often the helicopter is used. Providers contacted by GAO noted that a small portion of their costs—such as fuel—are variable, meaning they increase with the number of transports completed. To be profitable, and thus be in business and provide service, providers must earn sufficient revenues to cover their costs, including their fixed costs. To increase revenue, a provider must increase its number of transports or its prices charged. When a provider has a lower transport volume, then that provider must earn higher prices on average across transports in order to be profitable. Representatives from the eight selected providers GAO contacted reported average costs per transport, given current transport volumes, of $6,000 to $13,000 in 2016.[27] Factors such as a provider's proportion of transports provided by payer and competition may play a role in air ambulance prices charged, but data to assess these factors are not available.

Selected stakeholders the GAO contacted proposed actions to address air ambulance pricing issues, including (1) raising Medicare rates; (2) allowing state-level regulation of air ambulance prices; and (3) improving data collection for the purposes of investigations and transparency regarding prices.

Federal Air Ambulance and Patient Billing Advisory Committee

On October 5, 2018, President Trump signed the FAA Reauthorization Act of 2018 (FAA Act).[28] The FAA Act requires the Secretary of Transportation, in consultation with the Secretary of Health and Human Services, to establish an advisory committee[29] to review options to improve the disclosure of charges and fees for air medical services, inform consumers of insurance options for such services, and protect consumers from balance billing. The committee held its first meeting on January 15, 2020. The committee must submit a report containing recommendations to the Secretary of Transportation and others no later than 120 days after the first committee meeting.

Legislation and Litigation Relating to State Regulation of Air Ambulance Rates

A number of states have attempted to enact laws to protect consumers from balance billings by out-of-network air ambulances through the enactment of laws addressing reimbursement of air ambulance providers, but the Airline Deregulation Act of 1978 has preempted the laws.

Florida

Bailey v. Rocky Mountain Holdings, LLC[30], concerns whether the ADA preempts a cause of action against an air ambulance provider based on a statutory medical fee schedule for personal

[27] *Id.*
[28] *See* Pub. L. No. 115-254, 132 Stat. 3186 (2018).
[29] Department of Transportation, Air Ambulance and Patient Billing Advisory Committee (AAPB Advisory Committee) at https://www.transportation.gov/airconsumer/AAPB (last viewed Jan. 13, 2020).
[30] Bailey v. Rocky Mountain Holdings, LLC, 889 F.ed 1259 (11th Cir. 2018).

injury protection (PIP)[31] reimbursement under the Florida Motor Vehicle No-Fault Law.[32] Under PIP, a medical provider may not bill the insured for any amount in excess of such limits, except for amounts that are not covered by the insured's PIP coverage due to the coinsurance amount or maximum policy limits.[33]

In this case, an air ambulance provider submitted a bill for covered emergency transportation to the insurer; however, the policy limited reimbursement of the services under the fee schedule to less than the invoiced amount. The provider sought payment from the insured for the unpaid portion of its bill. The insured brought a class action suit against the provider seeking a declaration that the balance billing provision limited its reimbursement to the amount fixed in the fee schedule. In response, the provider moved to dismiss the action on grounds that the ADA preempted the enforcement of the balance billing provision. The insured contended that the McCarron-Ferguson Act, which provides that federal laws cannot preempt "any law enacted by any state for the purpose of regulating the business of insurance," precluded the ADA's preemption of the insured's action. The District Court concurred with the provider and held that the ADA preempted the insured's action because it related to the prices of the air carrier.[34] The McCarron-Ferguson Act, the Court determined prevents only inadvertent intrusion from federal legislation, not express preemption such as that of the ADA.

The insured appealed the decision to the Eleventh Circuit Court of Appeals. The panel concurred with the District Court that the (PIP) statute improperly restricted an air ambulance operator's rates by first limiting the reimbursement for such services to a schedule of charges based on Medicare rates, and then prohibiting the operator from billing the insured for the balance of the unpaid invoices.[35]

Montana

In 2017, Montana enacted a state law that imposes a hold-harmless requirement on insurers or HMOs for charges pertaining to out-of-network air ambulance transports. Insurers or HMOs assume responsibility for amounts charged to a covered person in excess of both allowed amounts and applicable cost-sharing amounts. It also requires the use of a nonbinding dispute resolution process, including a determination of the fair market price of the services provided, before an aggrieved party may pursue any remedy in court.[36]

North Dakota

In 2017 legislation was enacted that provides, effective January 1, 2018, insurers are required to pay for out-of-network air ambulance transports at the average of the insurer's in-network rates for air ambulance providers in the state. The law also provides that this payment is deemed full and final payment by the covered person for the transport.[37] The air ambulances subsequently

[31] Florida drivers are required to purchase both PIP insurance. The personal injury protection must provide a minimum benefit of $10,000 for bodily injury to any one person who sustains an emergency medical condition and includes emergency transport. *See* ss. 324.022, and 627.736, F.S.
[32] Florida's Motor Vehicle No-Fault Law, ss. 627.730-627.7405, F.S.
[33] Section 627.736(5), F.S.
[34] *Bailey v. Rocky Mountain Holdings, LLC,* 136F.Supp.3d 1376.
[35] *Bailey v. Rocky Mountain Holdings,* 889 F. 3d 1259 (11th Cir. 2018).
[36] Mont. Code Ann. ss. 33-2-2302 and 33-2-2305 (as added by S.B. 44 (2017)).
[37] N.D. Cent. Code s. 26.1-47-09 (as added by S.B. 2231 (2017)).

challenged the law in January 2018. In January 2019, the federal district court concluded that this payment provision is preempted by the ADA.[38] In February 2019, the state Insurance Commissioner announced plans for North Dakota to appeal this ruling to the U.S. Court of Appeals.

Texas

Legislation was enacted, relating to the Texas workers' compensation program, that provided if payments for patients were made pursuant to applicable rate guidelines, the payment must be accepted as payment in full.[39] The Division of Workers' Compensation of the Texas Department of Insurance began applying this requirement to air ambulance services in 2016. The air ambulances challenged the law in federal district court, and the court recently decided that the ADA preempts enforcement of workers' compensation rate restrictions on air ambulance services.[40]

Areas of Critical State Concern

The Administration Commission, which is composed of the Governor and Cabinet, designate areas of critical state concern.[41] Areas that qualify for designation include only:

> An area containing, or having a significant impact upon, environmental or natural resources of regional or statewide importance, including, but not limited to, state or federal parks, forests, wildlife refuges, wilderness areas, aquatic preserves, major rivers and estuaries, state environmentally endangered lands, Outstanding Florida Waters, and aquifer recharge areas, the uncontrolled private or public development of which would cause substantial deterioration of such resources.[42]

Once designated, the area's land planning regulations must comply with the principles guiding development specified by the Administration Commission, which must be approved by the Department of Economic Development.[43] Several areas have been designated as an area of critical state concern or have had their designations ratified by statute, and include the Big Cypress Area,[44] the Green Swamp Area,[45] the Apalachicola Bay Area,[46] and the Florida Keys Area.[47]

III. Effect of Proposed Changes:

Section 1 creates s. 627.42397, F.S., to require each health insurer to provide reasonable reimbursement to air ambulance services for covered nonemergency and emergency services

[38] See *Guardian Flight LLC v. Godfread*, No. 1:18-cv-007 (D.N.D. order filed Jan. 14, 2019).
[39] Tex. Lab. Code s. 413.011 (2017); 28 Tex. Admin. Code ss. 134.1(a), 134.203(d) (2017).
[40] *Air Evac EMS, Inc. v. Sullivan*, 331 F. Supp. 3d 650 (W.D. Tex., 2018) (U.S. District Ct. granted injunctive relief, prohibiting state from enforcing rate restrictions).
[41] Section 380.05, F.S.
[42] Section 380.05(2), F.S.
[43] Section 380.05(6), F.S.
[44] Section 380.055, F.S.
[45] Section 380.0551, F.S.
[46] Section 380.0555, F.S.
[47] Section 380.0552, F.S.

provided to an insured or subscriber in accordance with the coverage terms of the policy or contract. Such reimbursement may be reduced only by copayments, coinsurance, and deductibles. Further, such reimbursement must serve as full and final payment to the air ambulance service.

The bill defines the following terms: "air ambulance service," "health insurer," "health maintenance organization," and "reasonable reimbursement." The term, "reasonable reimbursement," means reimbursement that considers the actual cost of services rendered; the operation of air ambulance service by a county, which operates entirely within a designated area of critical state concern as determined by the Department of Economic Opportunity; and usual and customary reimbursement.

Section 2 creates s. 641.514, F.S., to apply the provisions of Section 1 to HMOs.

Section 3 provides that if any provision of s. 627.42397, F.S., (Section 1 of the bill) or s. 641.514, F.S., (Section 2 of the bill) is determined to be invalid or inoperative, the remaining provisions are deemed void and of no effect. The Legislature finds that the two provisions are not severable.

Section 4 provides the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, s. 18 of the Florida Constitution governs laws that require counties and municipalities to spend funds or that limit their ability to raise revenue or receive state tax revenues. Except upon approval of each house of the Legislature by two-thirds vote of the membership, the Legislature may not enact, amend, or repeal any general law if the anticipated effect of doing so would be to reduce the authority that municipalities or counties have to raise revenue in the aggregate, as such authority existed on February 1, 1989. However, the mandates requirements do not apply to laws having an insignificant impact, which for Fiscal Year 2019-2020 is approximately $2.1 million or less.

Cities or counties that provide such services directly or indirectly may incur an indeterminate fiscal impact due to the implementation of the reasonable reimbursement prescribed in the bill. If the reimbursement by an insurer or health maintenance organization to a county or city providing air ambulance services is decreased as a result, an indeterminate amount of additional funding sources may be necessary to fund these local services.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Since the bill effectively prohibits balance billing by air ambulance providers, the bill will hold privately-insured patients harmless in the event they incur medical bills from an out-of-network provider.

The provisions of the bill would not apply to coverage offered by self-insured plans[48] offered by employers, which are governed by federal law, or federal programs such as Medicare, Medicaid, or State Children's Health Insurance Program.

C. Government Sector Impact:

None.[49]

VI. Technical Deficiencies:

Sections 1 and 2 of the bill define "reasonable reimbursement" to require that the amount "considers" the operation of air ambulances service by a county which operates entirely within a designated area of critical state concern and in-network reimbursement by the insurer or HMO, respectively. It is unclear how an insurer or HMO would demonstrate that consideration when making a rate filing with the Office of Insurance Regulation and whether that consideration should be reflected as an upward or downward deviation in reimbursement.

Lines 40-42 provide that the reimbursement "must serve as full and final payment to the air ambulance service." Given the generally broad interpretation given to the Airline Deregulation Act of 1978's prohibition on state regulation of airline rates (including air ambulance services), it is unclear whether this would serve as a prohibition on balance billing or would be struck down upon challenge.[50]

[48] The Employee Retirement Income Security Act of 1974 (ERISA).
[49] Department of Management Services, *Agency Legislative Analysis of SB 736* (Dec. 2, 2019).
[50] The Florida Office of Insurance Regulation, *Agency Legislative Analysis of SB 736* (Nov. 19, 2019).

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 627.42397 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 21, 2020:
The CS clarifies the application of the bills' provisions to health maintenance organizations and provides other technical changes.

B. Amendments:

None.

198296

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/21/2020	.	
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	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 23 - 48

and insert:

(c) "Reasonable reimbursement" means reimbursement that considers the actual cost of services rendered, the operation of an air ambulance service by a county which operates entirely within a designated area of critical state concern as determined by the Department of Economic Opportunity, and in-network reimbursement established by the insurer for the specific

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policy. The term does not include billed charges for the cost of services rendered.

(2) A health insurance policy must require a health insurer to provide reasonable reimbursement to an air ambulance service for covered nonemergency and emergency services provided to an insured in accordance with the coverage terms of the policy. Such reasonable reimbursement may be reduced only by applicable copayments, coinsurance, and deductibles. The reasonable reimbursement must serve as full and final payment to the air ambulance service.

Section 2. Section 641.514, Florida Statutes, is created to read:

641.514 Coverage for air ambulance services.—

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

(a) "Air ambulance service" has the same meaning as provided in s. 401.23.

(b) "Reasonable reimbursement" means reimbursement that considers the actual cost of services rendered, the operation of an air ambulance service by a county which operates entirely within a designated area of critical state concern as determined by the Department of Economic Opportunity, and in-network reimbursement established by the health maintenance organization for the specific health maintenance contract. The term does not include billed charges for the cost of services rendered.

(2) A health maintenance contract must require a health maintenance organization to provide reasonable reimbursement to an air ambulance service for covered nonemergency and emergency services provided to a subscriber in accordance with the coverage terms of the contract. Such reasonable reimbursement

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may be reduced only by applicable copayments, coinsurance, and deductibles. The reasonable reimbursement must serve as full and final payment to the air ambulance service.

Section 3. If any provision of s. 627.42397 or s. 641.514, Florida Statutes, as created by this act is determined to be invalid or inoperative for any reason, the remaining provisions thereof shall be deemed to be void and of no effect. To this end, the Legislature declares that it would not have enacted any of the provisions of s. 627.42397 or s. 641.514, Florida Statutes, individually, and expressly finds them not to be severable.

Section 4. 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 lines 3 - 10

and insert:

services; creating ss. 627.42397 and 641.514, F.S.; defining terms; requiring health insurers and health maintenance organizations, respectively, to provide reasonable reimbursement to air ambulance services for certain covered services; providing that such reimbursement may be reduced only by certain amounts; providing that reasonable reimbursement must serve as full and final payment to the air ambulance service; providing that provisions of this act are not severable;

By Senator Diaz

36-00958A-20 2020736__

A bill to be entitled

An act relating to coverage for air ambulance services; creating s. 627.42397, F.S.; defining terms; requiring health insurers and health maintenance organizations to provide reasonable reimbursement to air ambulance services for certain covered services; providing that such reimbursement may be reduced only by certain amounts; providing that reasonable reimbursement must serve as full and final payment to the air ambulance service; providing applicability; providing an effective date.

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

Section 1. Section 627.42397, Florida Statutes, is created to read:

627.42397 Coverage for air ambulance services.—

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

(a) "Air ambulance service" has the same meaning as provided in s. 401.23.

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603.

(c) "Health maintenance organization" has the same meaning as provided in s. 641.19(12).

(d) "Reasonable reimbursement" means reimbursement that considers the actual cost of services rendered, the operation of air ambulances in areas of critical need, the operation of an air ambulance service by a county which operates entirely within a designated area of critical state concern as determined by the

36-00958A-20 2020736__

Department of Economic Opportunity, and usual and customary reimbursement.

(2) A health insurance policy or health maintenance contract must require a health insurer or health maintenance organization to provide reasonable reimbursement to air ambulance services for covered nonemergency and emergency services provided to an insured or subscriber in accordance with the coverage terms of the policy or contract. Such reasonable reimbursement may be reduced only by applicable copayments, coinsurance, and deductibles, unless the insured or subscriber has expressly or in fact contracted for a different amount. The reasonable reimbursement must serve as full and final payment to the air ambulance service.

(3) This section does not apply to a policy or contract providing any health care benefit pursuant to Title XVIII (Medicare), Title XIX (Medicaid), or Title XXI (the Children's Health Insurance Program) of the Social Security Act or any regulations promulgated thereunder.

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

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 13, 2020

I respectfully request that **Senate Bill # 736**, relating to Coverage for Air Ambulance Services, be placed on the:

☐ Committee agenda at your earliest possible convenience.

☒ Next committee agenda.

Senator Manny Diaz, Jr.
Florida Senate, District 36

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)

1/21/20
Meeting Date

736
Bill Number (if applicable)

Topic Air Ambulance

Amendment Barcode (if applicable)

Name Jim Milligan

Job Title Chief

Address 4360 - 55 Av N
Street

St Pete FL 33714
City *State* *Zip*

Phone 727-520-5650

Email jmilligan@leemcnfire.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Florida Fire Chiefs Assoc.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/2020
Meeting Date

SB 736
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Air Ambulance

Name Steve Hudson

Job Title Deputy Chief - Monroe County Fire

Address 490 63rd Street
Street

Phone 305-289-6004

Marathon FL 33050
City *State* *Zip*

Email hudson-steven@monroecounty-fl.gov

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Monroe County Fire

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

SB 736
Bill Number (if applicable)

Topic Air Ambulance - 736

Amendment Barcode (if applicable)

Name Ruthie Barko

Job Title Dir. Government Affairs, Air Methods

Address 10581 S. Cedar St.
Street

Phone 720-308-0842

Littleton CO 80120
City *State* *Zip*

Email ruthie.barko@airmethods.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Air Methods

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/2020
Meeting Date

736
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Air Ambulance

Name Audrey Brown

Job Title President/CEO

Address 200 W. College Ave.
Street

Phone (850) 386-2904

Tallahassee — *City* | FL — *State* | 32301 — *Zip*

Email audrey@fahp.net

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

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 914
INTRODUCER:	Banking and Insurance Committee and Senator Brandes
SUBJECT:	Contingency Risk Multipliers
DATE:	January 21, 2020
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 914 codifies into state law the federal precedent regarding the award of attorney fees using the lodestar amount and contingency fee multipliers as applied in property insurance cases, as articulated in *Perdue*.[1] The bill creates a strong presumption that the lodestar amount is sufficient and reasonable. The bill provides further that the lodestar "sufficient and reasonable" presumption is rebuttable only in "rare and exceptional" circumstances by evidence that competent counsel could not be retained in a reasonable manner. Only when such evidence is presented to the court could a contingency risk multiplier be applied in property insurance litigation.

The lodestar amount, in the context of attorney fees awarded under s. 627.428, F.S., is the number of hours reasonably expended on the litigation multiplied by a reasonable hourly rate for the services of the attorney of the insured or beneficiary.

The bill takes effect July 1, 2020.

[1] *See infra* Note 17.

II. Present Situation:

Attorney Fees in Insurance Litigation

In most United States jurisdictions, each party to the litigation pays its own attorney, regardless of the outcome of the litigation, and a court may only award attorney fees to the prevailing side if authorized by statute or agreement of the parties to the litigation.[2] This is often referred to as the "American Rule" for attorney fees, and contravenes the "English Rule" under which English courts generally awarded attorney fees to the prevailing party in litigation.[3]

Florida has enacted a number of statutes that authorize the award of attorney fees in civil litigation. As the Florida Supreme Court (Court) has noted, these statutory provisions are of two types.[4] In the first, statutes direct the courts to assess attorney fees against only one side of the litigation in certain types of actions. An example is found in s. 627.428, F.S., which directs the court to assess the insurer a reasonable sum as fees for the prevailing party's attorney. The second category adopts the English Rule, authorizing the prevailing party, whether plaintiff or defendant, to recover attorney fees from the opposing party. An example is found in the recently enacted s. 627.7152, F.S., which directs the court to award an attorney fee to the prevailing party in assignment of benefits litigation under a residential or commercial property insurance policy.

Attorney Fees Arising from Insurance Litigation

Section 627.428, F.S., allows an insured to recover his or her own attorney fees if the insured prosecutes a lawsuit to enforce an insurance policy. Some version of this statute has been the law in Florida since at least 1893.[5] The statute provides, in part:

> Upon the rendition of a judgment or decree by any of the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy or contract executed by the insurer, the trial court or, in the event of an appeal in which the insured or beneficiary prevails, the appellate court shall adjudge or decree against the insurer and in favor of the insured or beneficiary a reasonable sum as fees or compensation for the insured's or beneficiary's attorney prosecuting the suit in which the recovery is had.[6]

The Court recently explained the purpose of the statute:

> The need for fee and cost reimbursement in the realm of insurance litigation is deeply rooted in public policy. Namely, the Legislature recognized that it was essential to "level the playing field" between the economically-advantaged and sophisticated insurance companies and the individual citizen. Most assuredly, the

[2] *Florida Patient's Compensation Fund v. Rowe*, 472 So. 2d 1147-1148, (Fla. 1985).
[3] *Id*.
[4] *Id*.
[5] See *Tillis v. Liverpool & London & Globe Insurance Company*, 35 So. 171 (1903)(rejecting an insurance company argument that the 1893 law providing that an insured may recover attorney fees in actions against an insurance company to enforce a policy violates due process and equal protection).
[6] Section 626.9373, F.S., contains substantially similar language but it applies to surplus lines insurers. Florida courts have interpreted the statutes to have the same meaning.

> average policyholder has neither the finances nor the expertise to single-handedly take on an insurance carrier. Without the funds necessary to compete with an insurance carrier, often a concerned policyholder's only means to take protective action is to hire that expertise in the form of legal counsel… For this reason, the Legislature recognized that an insured is not made whole when an insurer simply grants the previously denied benefits without fees. The reality is that once the benefits have been denied and the plaintiff retains counsel to dispute that denial, additional costs that require relief have been incurred. Section 627.428, F.S., takes these additional costs into consideration and levels the scales of justice for policyholders by providing that the insurer pay the attorney's fees resulting from incorrectly denied benefits.[7]

Florida courts have broadly interpreted the statute to allow recovery of fees when the insurer ultimately settles the case before trial.[8] A finding of bad faith on the part of the insurer is not a necessary precondition for the award of fees under the statute.[9]

Lodestar Calculation

Florida courts set reasonable attorney fees using the federal lodestar approach, which is calculated as the product of the number of hours reasonably expended multiplied by a reasonable hourly rate.[10] In adopting a "suitable foundation for an objective structure" for the award of attorney fees, the Court explained in *Fla. Patient's Comp. Fund v. Rowe*, that:

> There is but little analogy between the elements that control the determination of a lawyer's fee and those which determine the compensation of skilled craftsmen in other fields. Lawyers are officers of the court. The court is an instrument of society for the administration of justice. Justice should be administered economically, efficiently, and expeditiously. The attorney's fee is, therefore, a very important factor in the administration of justice, and if it is not determined with proper relation to that fact it results in a species of social malpractice that undermines the confidence of the public in the bench and bar. It does more than that. It brings the court into disrepute and destroys its power to perform adequately the function of its creation.[11]

In calculating the lodestar amount under *Rowe*, courts must consider the following elements:

- The time and labor required, the novelty and difficulty of the question involved, and the skill requisite to perform the legal service.

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[7] *Johnson v. Omega Ins. Co.*, 200 So.3d 1207, 1215-1216 (Fla. 2016)(internal citations omitted).
[8] *Johnson v. Omega Ins. Co.*, 200 So.3d 1207, 1215 (Fla. 2016)(noting that it is it is "well settled that the payment of a previously denied claim following the initiation of an action for recovery, but prior to the issuance of a final judgment, constitutes the functional equivalent of a confession of judgment").
[9] *Insurance Co. of North America v. Lexow*, 602 So.2d 528, 531 (Fla. 1992)("We reject the argument that attorney's fees should not be assessed against INA because this dispute involved a type of claim which reasonably could be expected to be resolved by a court. INA's good faith in bringing this suit is irrelevant. If the dispute is within the scope of s. 627.428, F.S., and the insurer loses, the insurer is always obligated for attorney's fees").
[10] *Fla. Patient's Comp. Fund v. Rowe*, 472 So.2d 1145, 1150 (Fla. 1985).
[11] *Id*. at 1149 (quoting *Baruch v. Giblin*, 122 Fla. 59, 63, 164 So. 831, 833 (1935)).

- The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer.
- The fee customarily charged in the locality for similar legal services.
- The amount involved and the results obtained.
- The time limitations imposed by the client or by the circumstances.
- The nature and length of the professional relationship with the client.
- The experience, reputation, and ability of the lawyer or lawyers performing the services.
- Whether the fee is fixed or contingent. [12]

Contingency Risk Multipliers

Florida Court Discretion to Apply a Contingency Risk Multiplier and the Contingency Risk Multiplier Schedule

Florida courts have discretion to apply a contingency risk multiplier to the produced lodestar amount.[13] However, in determining whether a multiplier is warranted, Florida courts must consider the following elements to determine whether a multiplier is warranted:

- Whether the relevant market requires a contingency fee multiplier to obtain competent counsel.
- Whether the attorney was able to mitigate the risk of nonpayment in any way.
- Whether any of the factors set forth in *Rowe* are applicable, especially, the amount involved, the results obtained, and the type of fee arrangement between the attorney and the client.[14]

When courts conclude the presented evidence supports utilization of a multiplier, courts may use the following *Quanstrom* multiplier schedule:[15]

Contingency Risk Multiplier	Case's Likelihood of Success at Outset
1.0 to 1.5	More likely than not.
1.5 to 2.0	Approximately even.
2.0 to 2.5	Unlikely.

Florida's adoption of this approach in *Rowe* was followed by a series of United States Supreme Court (SCOTUS) decisions rejecting and limiting the use of contingency fee multipliers in federal cases. In response, the Court has reaffirmed Florida precedent and the underlying public policy reasoning for the use of contingency fee multipliers as articulated in *Rowe* on multiple occasions.

Federal Precedent Limiting the Use of Contingency Risk Multipliers

Following the Court's decision in *Rowe*, Justice Scalia, writing the SCOTUS majority opinion in *Dague*, couched his disapproval of contingency fee multipliers by reasoning that the multipliers incentivize nonmeritorious claims, so that those claims are effectively raised as often as meritorious claims:

[12] *Fla. Patient's Comp. Fund v. Rowe*, 472 So.2d 1145, 1150 (Fla. 1985).
[13] *Standard Guar. Ins. Co. v. Quanstrom*, 555 So.2d 828, 834 (Fla. 1990).
[14] *Id.*
[15] *Id*.

> [T]he consequence of awarding contingency enhancement to take account of this "merits" factor would be to provide attorneys with the same incentive to bring relatively meritless claims as relatively meritorious ones. Assume, for example, two claims, one with underlying merit of 20%, the other of 80%. Absent any contingency enhancement, a contingent-fee attorney would prefer to take the latter, since he is four times more likely to be paid. But with a contingency enhancement, this preference will disappear: the enhancement for the 20% claim would be a multiplier of 5 (100/20), which is quadruple the 1.25 multiplier (100/80) that would attach to the 80% claim. Thus, enhancement for the contingency risk posed by each case would encourage meritorious claims to be brought, but only at the social cost of indiscriminately encouraging nonmeritorious claims to be brought as well. We think that an unlikely objective of the "reasonable fees" provisions.[16]

Building on *Dague*, SCOTUS in *Perdue* further limited the use of contingency fee multipliers, reserving them for "rare and exceptional circumstances" in which the lodestar insufficiently accounts for a factor that may properly be considered in determining a reasonable fee.[17] Such circumstances "require specific evidence that the lodestar fee would not have been 'adequate to attract competent counsel.'"[18]

Florida Precedent Approving the Use of Contingency Risk Multipliers

The Court has rejected the SCOTUS reasonings in *Dague* and *Perdue* on multiple occasions. Beginning with *Bell*, the Court reaffirmed the *Rowe* rationale for contingency fee multipliers, explaining:

> [W]e find that the primary policy that favors the consideration of the multiplier is that it assists parties with legitimate causes of action or defenses in obtaining competent legal representation even if they are unable to pay an attorney on an hourly basis. In this way, the availability of the multiplier levels the playing field between parties with unequal abilities to secure legal representation.[19]

In *Lane*, the Court similarly noted the role full contingency fee cases, generally, and partial contingency fee cases, specifically, play in providing access to the court system:

> Attorneys should be encouraged to take cases based on a partial contingency-fee arrangement, since this policy also will encourage attorneys to provide services to persons who otherwise could not afford the customary legal fee. No incentive would exist under the approach taken by the district court below, because no "enhancement" of the customary fee would be given to offset losses.[20]

More recently, the Court has rejected the "rare and exceptional" standard as articulated in *Perdue*. In *Joyce*, the Court held there is no "rare and exceptional" circumstances requirement

[16] *City of Burlington v. Dague*, 505 U.S. 557, 563 (1992).
[17] *Perdue v. Kenny A. ex rel. Winn*, 559 U.S. 542, 543 (2010).
[18] *See Perdue* 559 U.S. at 543.
[19] *Bell v. U.S.B. Acquisition Co. Inc.*, 734 So.2d 403, 411 (Fla. 1999).
[20] *Lane v. Head*, 566 So.2d 508, 511 (Fla. 1990).

before a court can apply a contingency fee multiplier.[21] *Joyce* also reaffirmed *Rowe, Quanstrom*, and *Bell.*

Additional Statutes Applicable to the Award of Attorney Fees In Property Insurance Litigation

Section 627.428, F.S., generally governs the award of attorney fees in civil litigation under a property insurance policy. There are circumstances, however, where the insurer may obtain attorney fees from an insured. These circumstances include when litigation is brought by an assignee of benefits under a residential property insurance policy, when a claimant brings an action that has no good faith legal or genuine factual basis, or in certain circumstances when the insurer's offer of settlement is refused.

Attorney Fees Arising from Assignment of Benefits

Section 627.7152, F.S., prevents recovery of "one way" attorney fees under s. 627.428, F.S., for assignees of post-loss benefits under a residential property insurance policy or commercial property insurance policy, and instead provides a formulaic means by which either party may recover attorney fees.[22] An award of attorney fees is based on the difference between the judgment obtained and the presuit settlement offer. Fees are awarded as follows:

- If the difference between the judgment obtained and the presuit offer is less than 25 percent of the disputed amount, the insurer is entitled to an award of reasonable attorney fees.
- If the difference between the judgment obtained and the presuit offer is at least 25 percent but less than 50 percent of the disputed amount, no party is entitled to an award of attorney fees.
- If the difference between the judgment obtained and the presuit offer is at least 50 percent of the disputed amount, the assignee is entitled to an award of reasonable attorney fees.[23]

Attorney Fees Arising from Unsupported Claims, Defenses, or Delays

Section 57.105, F.S., provides the court with authority to award attorney fees, including prejudgment interest, to the prevailing party if the court finds the losing party or losing party's attorney brought a civil claim or raised a defense in a civil cause of action that has no good faith legal or genuine factual basis. The court may also award attorney fees if the opposing party took any action, including, but not limited to, the filing of any pleading or part thereof, the assertion of or response to any discovery demand, the assertion of any claim or defense, or the response to any request by any other party, for the primary purpose of unreasonable delay.[24]

Attorney Fees Arising from Offers of Judgment

Section 768.79, F.S., provides for attorney's fees where a party's offer to settle a case has been rejected. The statute states, in part:

> (1) In any civil action for damages filed in the courts of this state, if a defendant files an offer of judgment which is not accepted by the plaintiff within 30 days,

[21] *Joyce v. Federated National Insurance Company*, 228 So.3d 1122, 1135 (Fla. 2017).
[22] Chapter 2019-58, s. 23, L.O.F.
[23] Section 627.7152(10)(a), F.S.
[24] Section 57.105(2), F.S.

> the defendant shall be entitled to recover reasonable costs and attorney's fees incurred by her or him…if the judgment is one of no liability or the judgment obtained by the plaintiff is at least 25 percent less than such offer….If a plaintiff files a demand for judgment which is not accepted by the defendant within 30 days and the plaintiff recovers a judgment in an amount at least 25 percent greater than the offer, she or he shall be entitled to recover reasonable costs and attorney's fees….

An offer must:
- Be in writing and state that it is being made pursuant to this section;
- Name the party making it and the party to whom it is being made;
- State with particularity the amount offered to settle a claim for punitive damages, if any; and
- State its total amount.[25]

When determining the reasonableness of an award of attorney fees, the court must consider the following factors along with other relevant criteria:
- The then merit or lack of merit in the claim;
- The number and nature of offers made by the parties;
- The closeness of questions of fact and law at issue;
- Whether the person making the offer had unreasonably refused to furnish information necessary to evaluate the reasonableness of such offer;
- Whether the suit was in the nature of a test case presenting questions of far-reaching importance affecting nonparties; and
- The amount of the additional delay cost and expense that the person making the offer reasonably would be expected to incur if the litigation should be prolonged.

Section 768.79(7)(a), F.S., allows the court discretion to disallow an award of costs and attorney fees to the prevailing party if it is determined the prevailing party did not make the offer in good faith.

III. Effect of Proposed Changes:

Section 1 amends s. 627.428, F.S., to create a strong presumption that the lodestar fee is a sufficient and reasonable award of attorney fees in a claim arising under a property insurance policy. This presumption is rebuttable only in rare and exceptional circumstances with evidence that competent counsel could not be retained in a reasonable manner. Only when such evidence is presented to the court could a contingency risk multiplier be applied in property insurance litigation.

The lodestar amount, in the context of attorney fees awarded under s. 627.428, F.S., is the number of hours reasonably expended on the litigation multiplied by a reasonable hourly rate for the services of the attorney of the insured or beneficiary.

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

[25] Section 768.79(2), F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

The Court has noted the Legislature has discretion to limit the elements for consideration of attorney fee awards.[26] Similarly, the Court has noted application of contingency risk multipliers is not mandatory.[27]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[26] *See Quanstrom*, 555 So.2d at 834.
[27] *See Quanstrom*, 555 So.2d at 830.

VIII. Statutes Affected:

This bill substantially amends section 627.428 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 21, 2020:
Creates a strong presumption that the lodestar amount is a sufficient and reasonable award of attorney fees under s. 624.428, F.S., in property insurance litigation. The bill provides further that the lodestar "sufficient and reasonable" presumption is rebuttable only in "rare and exceptional" circumstances by evidence that competent counsel could not be retained in a reasonable manner. Only when such evidence is presented to the court could a contingency risk multiplier be applied in property insurance litigation. The original filed bill would have prohibited the use of a contingency risk multiplier in awarding an attorney fee under s. 624.428, F.S., related to property insurance litigation.

B. Amendments:

None.

806840

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/21/2020	.	
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	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 17 - 44

and insert:

(4) In an award of attorney fees under this section for a claim arising under a property insurance policy, a strong presumption is created that a lodestar fee is sufficient and reasonable. Such presumption may be rebutted only in a rare and exceptional circumstance with evidence that competent counsel could not be retained in a reasonable manner.

806840

11
12 ================ T I T L E A M E N D M E N T ================
13 And the title is amended as follows:
14 Delete lines 5 - 9
15 and insert:
16 insurance policies, a strong presumption is created
17 that a lodestar fee is sufficient and reasonable;
18 providing that such presumption may be rebutted only
19 under certain circumstances; providing an

232410

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/21/2020	.	
	.	
	.	
	.	

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

Senate Amendment

In title, delete line 2
and insert:
An act relating to contingency risk multipliers;
amending s.

By Senator Brandes

24-01110-20 2020914__

A bill to be entitled

An act relating to property insurance; amending s. 627.428, F.S.; providing that, for certain attorney fees awarded for claims arising under property insurance policies, the maximum fee a court may award is a lodestar fee; prohibiting the court from considering contingency risk or using a contingency risk multiplier; amending s. 627.736, F.S.; conforming a provision to changes made by the act; providing an effective date.

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

Section 1. Subsection (4) is added to section 627.428, Florida Statutes, to read:

627.428 Attorney fees.—

(4) In awarding attorney fees under this section for a claim arising under a property insurance policy, the maximum fee a court may award is a lodestar fee. A court may not consider contingency risk in determining the lodestar fee or use a contingency risk multiplier to increase the lodestar fee.

Section 2. Subsection (8) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(8) APPLICABILITY OF PROVISION REGULATING ATTORNEY FEES.— With respect to any dispute under the provisions of ss. 627.730-627.7405 between the insured and the insurer, or between an assignee of an insured's rights and the insurer, the provisions

24-01110-20 2020914__

of ss. 627.428 and 768.79 apply, except as provided in subsections (10) and (15), and except that any attorney fees recovered must:

(a) Comply with prevailing professional standards;

(b) Not overstate or inflate the number of hours reasonably necessary for a case of comparable skill or complexity; and

(c) Represent legal services that are reasonable and necessary to achieve the result obtained.

Upon request by either party, a judge must make written findings, substantiated by evidence presented at trial or any hearings associated therewith, that any award of attorney fees complies with this subsection. ~~Notwithstanding s. 627.428,~~ Attorney fees recovered under ss. 627.730-627.7405 must be calculated without regard to a contingency risk multiplier.

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

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 13, 2019

I respectfully request that **Senate Bill #914**, relating to **Property 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)

1/21/20
Meeting Date

914
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Contingency Risk Multiplier

Name MICHAEL CARLSON

Job Title President

Address 215 S. Monroe St. Ste. 835
Street

Phone 850 597 7425

Tall FL 32301
City *State* *Zip*

Email Michael.carlson@piff.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing PERSONAL INSURANCE FEDERATION

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

SB 914
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Property Insurance

Name Laura Pearce

Job Title General Counsel

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Association of Insurance Agents

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

01.21.20
Meeting Date

914
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Property Insurance

Name Aram Megerian

Job Title

Address 4301 West Boy Scout Blvd. - Ste. 400
Street

Phone 813-289-9300

Tampa FL 33607
City *State* *Zip*

Email aram.megerian@csklegal.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Justice Reform Institute

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21
Meeting Date

914
Bill Number (if applicable)

Topic Insurance Attorney Fees

Amendment Barcode (if applicable)

Name Amy Boggs

Job Title Chair, Florida Justice Association Property Committee

Address 4554 Central Ave Suite L
Street

Phone 727-954-8833

Saint Petersburg, FL 33704
City *State* *Zip*

Email ABOGGS@BOGGSLAWGROUP.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Justice 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)

01/21/20
Meeting Date

SB914
Bill Number (if applicable)

Topic Property Insurance

Amendment Barcode (if applicable)

Name Candace Bunker

Job Title Director - Legislative + Cabinet Affairs

Address 2101 Maryland Circle
Street

Phone 8505135757

Tallahassee FL 32303
City *State* *Zip*

Email candace.bunker@citizensfla.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Citizens Property Insurance Corporation

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21
Meeting Date

914
Bill Number (if applicable)

Topic Property Insurance Attorneys Fees

Amendment Barcode (if applicable)

Name William "Chip" Merlin

Job Title President, Merlin Law Group

Address 700 So Harbour Island Blvd #95 Phone 813 229-1000
Street

Tampa FL, 33602 Email cmerlin@merlinlawgroup.com
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Merlin Law Group

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/2020
Meeting Date

914
Bill Number (if applicable)

Topic Property Insurance

Amendment Barcode (if applicable)

Name Greg Black

Job Title Lobbyist

Address 1727 Highland Place
Street

Phone 509-8022

TLH FL 32308
City *State* *Zip*

Email greg@waypointstrat.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing R Street Institute

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

914
Bill Number (if applicable)

Topic Property Insurance

Amendment Barcode (if applicable)

Name Brewster Bevis

Job Title Senior VP

Address 516 N. Adams St
Street

Phone 850-224-7173

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

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 (10/14/1

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 1006
INTRODUCER:	Senator Baxley and others
SUBJECT:	Coverage for Hearing Aids for Children
DATE:	January 17, 2020
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Palecki	Knudson	BI	**Favorable**
2.			HP	
3.			AP	

I. Summary:

SB 1006 requires an individual market health insurance policy that provides coverage on an expense-incurred basis for a family member of the insured to provide coverage for hearing aids for children from birth through 21 years of age who have been diagnosed with hearing loss. The bill requires such policies to provide a minimum coverage limit of $3,500 per ear within a 24-month period.

The insured remains responsible for the cost of hearing aids and related services which exceed the coverage limit provided for in their policy. If, however, a child experiences a significant and unexpected change in his or her hearing or experiences a medical condition requiring an unexpected change in the hearing aid before the existing 24-month period expires, and alterations to the existing hearing aid do not, or cannot, meet the needs of the child, a new 24-month period shall begin with full benefits and coverage.

If the child diagnosed with hearing loss is under 18 years of age, then the covered hearing aids must be prescribed, fitted, and dispensed by a licensed audiologist. For children ages 18 through 21, covered hearing aids may be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist.

The bill applies to a policy that is issued or renewed on or after January 1, 2021, and shall take effect on the same date.

II. Present Situation:

Hearing Loss in Children

One in eight people in the United States (13 percent, or 30 million) aged 12 years or older has hearing loss in both ears, based on standard hearing examinations.[1] About 2 to 3 out of every 1,000 children in the United States are born with a detectable level of hearing loss in one or both ears.[2]

Florida Newborn Hearing Screening Program

Since October 1, 2000, Florida has had a universal newborn hearing screening program.[3] Unless a parent objects to the screening, all Florida-licensed facilities that provide maternity and newborn care are required to screen all newborns prior to discharge for the detection of hearing loss. All test results, including recommendations for any referrals or follow up evaluations from that screening by the licensed audiologist, a physician licensed under chs. 458 or 459, F.S., or other newborn hearing screening providers in the hospital facility, must be placed in the newborn's medical records within 24 hours after the completion of the screening procedure.[4] For babies born in a facility other than a hospital, the parents are to be instructed on the importance of having a screening conducted, information must be provided, and assistance given to make an appointment within three months.[5]

The initial newborn screening and any necessary follow-up and evaluation are covered insurance benefits reimbursable by Medicaid, health insurers, and health maintenance organizations, with some limited exceptions.[6] Newborns and children found to have a permanent hearing loss may take advantage of the state's Part C program of the Individuals with Disabilities Education Act[7] and Children's Medical Services' Early Intervention Program, Early Steps.[8]

Insurance Coverage for Hearing Aids

Private Health Insurance

According to the Office of Insurance Regulation, two carriers in the individual market and four carriers in the small group market had forms that cover hearing aids during 2019.[9]

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[1] *See* National Institutes for Health, National Institute on Deafness and Other Communication Disorders at https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing (last visited January 16, 2020).
[2] *Id.*
[3] *See* s. 383.145, F.S.
[4] Section 383.145(3)(e), F.S.
[5] Section 383,145(3)(i), F.S.
[6] Section 383.145(3)(j), F.S.
[7] *See* Pub. Law No. 108-446. The federal Part C program provides benefits and services for infants and toddlers from birth to age 36 months. Florida's Part C program is known as Early Steps and is administered by the Department of Health's Children's Medical Services.
[8] The Early Steps program services infants and children from age birth to age 36 months with disabilities, developmental delays, or children with a physical or mental condition known to create a risk of a developmental delay. *See* http://www.cms-kids.com/families/early_steps/early_steps.html (last visited January 16, 2020).
[9] Email from Office of Insurance Regulation staff to Committee staff dated March 18, 2019 (on file with the Committee on Banking and Insurance).

Twenty-four states appear to mandate health benefit plans to provide coverage for hearing aids for children.[10] Coverage requirements range from requiring a hearing aid every 24 months to every 5 years. Many states include caps on the amount the insurer must pay. These caps range from $1,000 to $4,000.[11]

Hearing Aid Coverage in Public Insurance Programs

Medicare does not cover hearing aids or hearing exams. Some Medicare Advantage Plans offer hearing coverage.[12] The Veterans Administration provides hearing aids for veterans in some circumstances.[13]

For adults, Florida's Medicaid program covers hearing aids.[14] For recipients who have moderate hearing loss or greater, the program includes the following services:

- One new, complete, (not refurbished) hearing aid device per ear, every 3 years, per recipient;
- Up to three pairs of ear molds per year, per recipient; and
- One fitting and dispensing service per ear, every 3 years, per recipient.

Medicaid also covers repairs and replacement of both Medicaid and non-Medicaid provided hearing aids, up to two hearing aid repairs every 366 days, after the 1 year warranty period has expired.[15]

For children, Florida Medicaid covers services that are medically necessary to any eligible recipient under the age of 21 to correct or ameliorate a defect, condition, or a physical, or mental illness under the Early Periodic Screening and Diagnostic Testing (EPSDT) standard. Within this coverage standard, Medicaid recipients under the age of 21 receive all diagnostic services, treatment, equipment, supplies, and other measures that are described under 42 U.S.C. 1396d(a).[16] In addition to the coverage described above, Medicaid recipients under age 21 have coverage for the following relating to hearing services:

- For recipients who have documented, profound, severe hearing loss in one or both ears as follows:
  - Implanted device for recipients age 5 years and older;
  - Non-implanted soft band device for recipients under age 5.
- Cochlear implants for recipient age 12 months and older who have documented, profound to severe, bilateral sensorineural hearing loss.
- One hearing assessment every 3 years for the purposes of determining hearing aid candidacy and the most appropriate hearing aid.

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[10] *See* information gathered by the American Speech-Language-Hearing Association at https://www.asha.org/advocacy/state/issues/ha_reimbursement.htm (last visited January 16, 2020).
[11] *Id.*
[12] *See* https://www.medicare.gov/coverage/hearing-aids (last visited January 16, 2020).
[13] *See* https://www.military.com/benefits/veterans-health-care/va-health-care-hearing-aids.html (last visited January 16, 2020).
[14] *See* Rule 59G-4.110, Florida Administrative Code. The hearing services coverage policy from the Agency for Health Care Administration is available at http://ahca.myflorida.com/medicaid/review/specific_policy.shtml (last visited January 16, 2020).
[15] *Id.*
[16] Agency for Health Care Administration, *Hearing Services Coverage Policy* (June 2016), http://ahca.myflorida.com/medicaid/review/specific_policy.shtml (last visited January 16, 2020).

- Up to two newborn screenings for recipients under the age of 12 months. A second screening may be conducted only if the recipient did not pass the test in one or both ears.
- Hearing screenings on the same date as a child health check-up.[17]

Title XXI – State Children's Health Insurance Program[18]

The Children's Health Insurance Program (CHIP) was created in 1997 through the 1997 Federal Balanced Budget Act legislation and it enacted Title XXI of the Social Security Act as a joint state-federal funding partnership to provide health insurance to children in low to moderate income households.[19] The Florida Healthy Kids Corporation[20] is one component of Florida's Title XXI program, known as Florida KidCare, which was enacted by the Florida Legislature in 1998[21] and is the only program component utilizing a non-Medicaid benefit package. The other program components, Medicaid for children, Medikids, and Children's Medical Services Network follow the Medicaid benefit package.[22]

Under s. 409.815(2)(a), F.S., in order for health benefits coverage to qualify for premium assistance payments, KidCare enrollees must receive hearing screenings as a covered, preventative health service. Additionally, under s. 409.815(2)(h), F.S., describing the benefits for durable medical equipment, covered services include:

> *…equipment and devices that are medically indicated to assist in the treatment of a medical condition and specifically prescribed as medically necessary, with the following limitations:*
> *…*
> *3. Hearing aids shall be covered only when medically indicated to assist in the treatment of a medical condition.*

There are no out of pocket cost for the well-child hearing screening and the provision of hearing aids for subsidized Title XXI eligible children.[23]

Mandated Health Insurance Coverages

Florida law does not require that health insurance policies cover hearing aids for adults or for children.

Section 624.215, F.S., requires every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, to submit to the Agency for Health Care Administration and the legislative committees having jurisdiction a report that assesses the social and financial impacts

[17] 42 U.S.C. ss. 1397aa-1397mm.
[18] *Id.*
[19] The Balanced Budget Act of 1997, Pub. Law 105-33. 111 Stat. 251, enacted August 5, 1997.
[20] *See* s. 624.91-624.915, F.S.
[21] *See* ss. 409.810-409.821, F.S.
[22] *See* s. 409.815(2)(a), F.S., and s. 391.0315, F.S.
[23] Florida Healthy Kids Corporation, *Medical Benefits*, https://www.healthykids.org/benefits/medical/ (last visited March 27, 2019).

of the proposed coverage.[24] Proponents have provided information to staff which indicates that less than 4,371 children under the age of 21 in Florida are deaf.[25] Hearing aids and the services to properly prescribe, evaluate, fit, and manage children with hearing loss generally cost an average of $3,500 per ear depending on the technology and enhancements selected by the audiologist based on the individual needs of the child.[26]

The Patient Protection and Affordable Care Act (PPACA)[27] does not require that health insurance policies cover hearing aids for adults or for children. Under PPACA, individuals and small businesses can shop for health insurance coverage on the federal marketplace. All non-grandfathered plans[28] must include minimum essential coverage (MEC),[29] including an array of services that includes the 10 essential health benefits (EHBs). These 10 EHBs are further clarified or modified each year through the federal rulemaking process and are open for public comment before taking effect. The 10 general categories for the EHBs are:

- Ambulatory services (outpatient care).
- Emergency services.
- Hospitalization (inpatient care)
- Maternity and newborn care.
- Mental health and substance abuse disorder services.
- Prescription drugs.
- Rehabilitative services and rehabilitative services and devices.
- Laboratory services.
- Preventive care and chronic disease management.
- Pediatric services, including oral and vision care.[30]

States are free to modify the EHBs offered in their states by adding coverage; however, because of concerns that federal funds would be used on costly mandated coverages that were not part of the required EHBs, PPACA contains a provision requiring that, starting in 2016, the states would have to pay for the cost of the coverage. As a result, Florida may be required to defray the costs

[24] AHCA has not yet received such a report. *See* E-mail from Deputy Director of Legislative Affairs to Senate Staff dated January 17, 2020 (on file with Senate Banking and Insurance Committee).
[25] Florida Coalition for Spoken Language Options, *Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children*. (on file with Senate Banking and Insurance Committee).
[26] *Id.*
[27] H.R. 3590 – 111th Congress: Patient Protection and Affordable Care Act (March 27, 2009). https://www.govtrack.us/congress/bills/111/hr3590 (last visited March 27, 2019).
[28] A "grandfathered health plan" are those health plans, both individual and employer plans, that maintain coverage that were in place prior to the passage of the PPACA or in which the enrollee was enrolled on March 23, 2010 while complying with the consumer protection components of the PPACA. If a group health plan enters a new policy, certificate, or contract of insurance, the group must provide the new issuer the documentation from the prior plan so it can be determined whether there has been a change sufficient to lose grandfather status. *See* 26 U.S.C. 7805 and 26 C.F.R. s. 2590.715-1251(a).
[29] To meet the individual responsibility provision of the PPACA statute, a benefit plan or coverage plan must be recognized as providing minimum essential coverage (MEC). Employer based coverage, Medicaid, Medicare, CHIP (i.e.: Florida KidCare), and TriCare would meet this requirement.
[30] 42 U.S.C. s. 18022(b)(1)(A)-(J).

of any additional benefits beyond the required EHBs put in place after 2011.[31] Florida has not enacted any mandated benefits since 2011.[32]

Examples of health insurance benefits mandated under Florida law include:
- Coverage for certain diagnostic and surgical procedures involving bones or joints of the jaw and facial region (s. 627.419(7), F.S.);
- Coverage for bone marrow transplants (s. 627.4236, F.S.);
- Coverage for certain cancer drugs (s. 627.4239, F.S.);
- Coverage for any service performed in an ambulatory surgical center (s. 627.6616, F.S.);
- Diabetes treatment services (s. 627.6408, F.S.);
- Osteoporosis (s. 627.6409, F.S.);
- Certain coverage for newborn children (s. 627.641, F.S.);
- Child health supervision services (s. 627.6416, F.S.);
- Certain coverages related to mastectomies (s. 627.6417, F.S.);
- Mammograms (s. 627.6418, F.S.); and
- Treatment of cleft lip and cleft palate in children (s. 627.64193, F.S.).

III. Effect of Proposed Changes:

Section 1 of the bill creates s. 627.6413, F.S., to require an individual market health insurance policy that provides coverage on an expense-incurred basis for a family member of the insured to provide coverage for hearing aids for children from birth through 21 years of age who have been diagnosed with hearing loss. Such policies are required to provide a minimum coverage limit of $3,500 per ear within a 24-month period.

The bill indicates that the insured remains responsible for the cost of hearing aids and related services which exceed the coverage limit provided for in their policy. However, if a child experiences a significant and unexpected change in his or her hearing or experiences a medical condition requiring an unexpected change in the hearing aid before the existing 24-month period expires, and alterations to the existing hearing aid do not or cannot meet the needs of the child, the bill requires that a new 24-month period shall begin with full benefits and coverage.

If the child diagnosed with hearing loss is under 18 years of age, then the covered hearing aids must be prescribed, fitted, and dispensed by a licensed audiologist. For children ages 18 through 21, covered hearing aids are allowed be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist.

The bill applies to a policy that is issued or renewed on or after January 1, 2021.

Section 2 provides an effective date of January 1, 2021.

[31] *See* 42 U.S.C. s. 18031(d)(3)(B)(ii).
[32] Centers for Medicare and Medicaid Services, *Florida – State Required Benefits,* https://downloads.cms.gov/cciio/State%20Required%20Benefits_FL.pdf (last visited January 16, 2020).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Approximately 1,709 children will benefit from the mandated coverage. Resulting increases in insurance premiums are estimated to be between $0.056 and $0.68 per member, per month.[33]

C. Government Sector Impact:

Federal law may require Florida to assume the cost of additional benefits that it requires of insurance companies.[34]

The proposed mandate is not expected to have a significant impact on the total cost of healthcare in the state of Florida.

- Total estimated number hearing aids:
  - Binaural (2) hearing aids: 1,623
  - Monaural (unilateral hearing loss) hearing aids 85

[33] Florida Coalition for Spoken Language Options, Impact of Senate Bill 1006: *Insurance Coverage for Hearing Aids for Children*. (on file with Senate Banking and Insurance Committee).
[34] *See* 42 U.S.C. s. 18031(3)(B)(ii).

- Costs at $3500 per ear
  - Binaural $11,363,173
  - Monaural $ 299,031
  - Total costs $11,662,204
  - 2-year benefit $ 5,831,102[35]

This bill does not directly impact the Florida Department of Management Services.[36]

VI. Technical Deficiencies:

This bill requires coverage for "hearing aids" for children, yet the term is undefined.

This bill requires individual market insurance policies to provide coverage for hearing aids for children upon a diagnosis of hearing loss. The bill does not indicate how the child must be diagnosed or by whom.

This bill provides that if the child is under 18 years of age, the hearing aids must be prescribed, fitted, and dispensed by a licensed audiologist. However, if the child is 18 to 21 years of age, the bill only requires that the hearing aids be fitted or dispensed by either a licensed audiologist or licensed hearing aid specialist; the bill does not specify who may or must prescribe hearing aids for a child aged 18-21 years. If the intent is to require a prescription for hearing aids from a licensed audiologist for all children, it may be necessary to amend the bill to clarify this point. This bill authorizes a licensed audiologist or licensed hearing aid specialist to fit and dispense a hearing aid for a child aged 18-21 years; it does not require that only licensed audiologists and licensed hearing aid specialists fit and dispense the hearing aids. If the intent is limit who may fit and dispense hearing aids, it may be necessary to amend the bill to clarify this point.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 627.6413 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.

[35] Florida Coalition for Spoken Language Options, *Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children*. (on file with Senate Banking and Insurance Committee).
[36] Letter from Department of Management Services dated January 8, 2020, on file with Senate Banking and Insurance Committee.

B. Amendments:

None.

By Senator Baxley

12-00626B-20 20201006__

A bill to be entitled

An act relating to coverage for hearing aids for children; creating s. 627.6413, F.S.; requiring certain individual health insurance policies to provide coverage for hearing aids for children 21 years of age or younger; specifying health care providers who may prescribe, fit, and dispense the hearing aids; specifying a minimum coverage limit within a certain timeframe; providing an exception; providing that an insured is responsible for certain costs that exceed the policy limit; providing applicability; providing an effective date.

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

Section 1. Section 627.6413, Florida Statutes, is created to read:

627.6413 Coverage for hearing aids for children.—

(1) A health insurance policy that provides coverage on an expense-incurred basis for a family member of the insured must provide coverage for hearing aids for children diagnosed with hearing loss from birth through 21 years of age. If the child is under 18 years of age, a hearing aid must be prescribed, fitted, and dispensed by a licensed audiologist. For a child who is 18 to 21 years of age, a hearing aid may be fitted and dispensed by a licensed audiologist or licensed hearing aid specialist.

(2) The policy must provide a minimum coverage limit of $3,500 per ear within a 24-month period. However, if a child experiences a significant and unexpected change in his or her

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hearing or a medical condition requiring an unexpected change in the hearing aid before the existing 24-month period expires, and alterations to the existing hearing aid do not or cannot meet the needs of the child, a new 24-month period must begin with full benefits and coverage.

(3) An insured is responsible for the cost of hearing aids and related services that exceed the coverage limit provided by his or her policy.

(4) This section applies to a policy that is issued or renewed on or after January 1, 2021.

Section 2. This act shall take effect January 1, 2021.

Palecki, AnnMichelle

From: Keenan, Lauren <lauren.keenan@ahca.myflorida.com>
Sent: Friday, January 17, 2020 9:10 AM
To: Palecki, AnnMichelle
Cc: Kotas, James
Subject: RE: Follow-Up from 10 AM Call

Good Morning, Ann Michelle –

I have checked with our Medicaid & Health Quality Assurance (HQA) units here at AHCA.
Neither of these units are receiving or have ever received any reports like the ones that you've mentioned below.

Hope this helps. Please let me know if you have any additional questions.
Thanks & have a great day!

Best,

Lauren

Lauren Keenan – Deputy Director of Legislative Affairs

AHCA HQ Bldg 3 Rm 3234 - DEPUTY CHIEF OF STAFF
+1 850-412-3626 (Office) -
lauren.keenan@ahca.myflorida.com

From: Palecki, AnnMichelle <Palecki.AnnMichelle@flsenate.gov>
Sent: Thursday, January 16, 2020 12:38 PM
To: Keenan, Lauren <lauren.keenan@ahca.myflorida.com>
Subject: RE: Follow-Up from 10 AM Call

Hi Lauren,

Thank you for following up! Section 624.215(2), Florida Statutes, provides that "every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, shall submit to the Agency for Health Care Administration and the legislative committees having jurisdiction a report which assesses the social and financial impacts of the proposed coverage." SB 1006 mandates coverage of hearing aids, so please let me know if AHCA has received anything along these lines.

Thank you again!

Best,

Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children

Prepared by The Florida Coalition for Spoken Language Options

Twenty-five states (AK, CT, CO, DE, GA, ID, IL, KY, LA, MA, MD, ME, MN, MO, NH, NJ, NM, NC, OH, OK, OR, TN, TX, RI, WI) require health benefit plans cover hearing aids for children. The proposed Florida requirement has adopted the best parts of those existing in other states and will make Florida a model for pediatric hearing care in the country.

Answering Florida Statutory Requirements:

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0624/Sections/0624.215.html

"...Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage, to the extent that information is available, shall include:

(a) To what extent is the treatment or service generally used by a significant portion of the population.
The Florida Department of Education reports less than 4,371 children as deaf through age 21. Additionally, it is possible to estimate the number of children with hearing loss from various sources including data from the National Institute on Deafness and Communication Disorders, the U.S. census, The Kaiser Family Foundation, data from the Florida Department of Health, and data from the Florida Department of Education.

According to the U.S. Census, there are an estimated 5,165,100 children between the ages of 0-21 in Florida, representing 25% of the population of Florida. The healthcare of these children is covered as follows:

- Medicaid children in Florida 2,214,221 (43.1%)
- Children's Health Insurance Program (CHIP) 340,000 (6.6%)
- Uninsured children in Florida 320,236 (6.3%)
- Covered by private health insurance 2,290,643 (44%)
- Total children 0-21 years 5,165,100 (100%)

Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children

Prepared by The Florida Coalition for Spoken Language Options

The estimated number of children 0-21 years of age in Florida with hearing loss is as follows:

- Children in Florida with hearing loss..... 4,371
- Children with private insurance and hearing loss..... 1,923
- Children with private insurance, hearing loss and over age 3..... 1,315
- Children with cochlear implant..... 931
- Total children benefiting from Florida Hearing Care for Children... 384

*Note: Children with cochlear implant(s) will not need a hearing aid in the implanted ear(s)

(b) To what extent is the insurance coverage generally available.

There is no existing law mandating coverage for hearing aids for private insurance. Despite this, in recent years some private insurance policies have begun to include hearing aid coverage regardless of age; however, this type of coverage is rare. For children ages 0-21 years in Florida, hearing aids for children are covered by the Early Steps Program (ages 0-3 years), Medicaid, and the Children's Health Insurance Programs (CHIP). These children have been excluded from this financial evaluation.

(c) If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.

The most recent survey of the general United States population that may provide some insight to the extent non-coverage has on hearing aid adoption was completed 4 years ago (Abrams & Kihm, 2015). This study found that 51% of people with hearing loss that did not have hearing aids ("non-owners") said that having insurance coverage would facilitate buying hearing aids.

Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children

Prepared by The Florida Coalition for Spoken Language Options

(d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.

Increased Healthcare Costs

- Longitudinal, peer-reviewed studies have shown that healthcare costs are significantly higher for individuals with untreated vs treated hearing loss.[1][2].
- Increased costs are not confined to the medical bills in the studies. Medical providers must absorb (and pass on via increased overall costs) costs incurred from longer visit times due to communication difficulties[3], increased risk of malpractice lawsuits from communication difficulties[4], and necessary accommodations like interpreter services.[5][6][7][8]
- Communication difficulties in deaf and hard of hearing patients, which would be mitigated by appropriate access to sound, result in more physician visits and overuse of emergency rooms and urgent care centers.[9]

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[1] Reed, N., Altan, A., Deal, J., Yeh, C., Kravetz, A., Wallhagen, M., & Lin, F. (2019). Trends in Health Care Costs and Utilization Associated With Untreated Hearing Loss Over 10 Years. *JAMA Otolaryngology–Head & Neck Surgery, 145*(1), 27. doi: 10.1001/jamaoto.2018.2875

[2] Simpson, A., Simpson, K., & Dubno, J. (2016). Higher Health Care Costs in Middle-aged US Adults With Hearing Loss. *JAMA Otolaryngology–Head & Neck Surgery, 142*(6), 607. doi: 10.1001/jamaoto.2016.0188

[3] Fagan, M., Diaz, J., Reinert, S., Sciamanna, C., & Fagan, D. (2003). Impact of interpretation method on clinic visit length. *Journal Of General Internal Medicine, 18*(8), 634-638. doi: 10.1046/j.1525-1497.2003.20701.x

[4] Legal Risks of Ineffective Communication. (2007). *Virtual Mentor, 9*(8), 555-558. doi: 10.1001/virtualmentor.2007.9.8.hlaw1-0708

[5] Jacobs, B., Ryan, A., Henrichs, K., & Weiss, B. (2018). Medical Interpreters in Outpatient Practice. *The Annals Of Family Medicine, 16*(1), 70-76. doi: 10.1370/afm.2154

[6] Questions and Answers for Health Care Providers. (2019). Retrieved from https://www.nad.org/resources/health-care-and-mental-health-services/health-care-providers/questions-and-answers-for-health-care-providers/

[7] Flores, G., Abreu, M., Barone, C., Bachur, R., & Lin, H. (2012). Errors of Medical Interpretation and Their Potential Clinical Consequences: A Comparison of Professional Versus Ad Hoc Versus No Interpreters. *Annals Of Emergency Medicine, 60*(5), 545-553. doi: 10.1016/j.annemergmed.2012.01.025

[8] Juckett, G., & Unger, K. (2019). Appropriate Use of Medical Interpreters. Retrieved from https://www.aafp.org/afp/2014/1001/p476.html

[9] Position Statement On Health Care Access For Deaf Patients. (2019). Retrieved from https://www.nad.org/about-us/position-statements/position-statement-on-health-care-access-for-deaf-patients/

Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children

Prepared by The Florida Coalition for Spoken Language Options

- Patients with untreated hearing loss are more likely to be misdiagnosed when visiting providers for unrelated health issues and are more difficult to treat due to communication difficulties.[10]

- Secondarily developing language, cognitive, behavioral and mental health diagnoses[11][12][13]lead to increased covered physician and therapy visits.

- Even a mild untreated hearing loss doubles the risk of dementia and cognitive decline. A severe to profound loss causes five times the risk.[14]

- Increased costs compound over time. Children with untreated hearing loss miss the window to develop effective spoken language and risk factors and secondary medical costs build. Even in post lingual hearing loss for adults, increased costs go from 26% more after two years to 46% more after 10[15].

- Deaf and hard of hearing children have a narrow window to develop effective spoken language[16]. Better outcomes are associated with earlier amplification and access to auditory oral

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[10] Position Statement On Health Care Access For Deaf Patients. (2019). Retrieved from https://www.nad.org/about-us/position-statements/position-statement-on-health-care-access-for-deaf-patients/

[11] Hogan, A., Shipley, M., Strazdins, L., Purcell, A., & Baker, E. (2011). Communication and behavioural disorders among children with hearing loss increases risk of mental health disorders. *Australian And New Zealand Journal Of Public Health*, *35*(4), 377-383. doi: 10.1111/j.1753-6405.2011.00744.x

[12] FELLINGER, J., HOLZINGER, D., SATTEL, H., LAUCHT, M., & GOLDBERG, D. (2009). Correlates of mental health disorders among children with hearing impairments. *Developmental Medicine & Child Neurology*, *51*(8), 635-641. doi: 10.1111/j.1469-8749.2008.03218.x

[13] Arlinger, S. (2003). Negative consequences of uncorrected hearing loss—a review. *International Journal Of Audiology*, *42*(sup2), 17-20. doi: 10.3109/14992020309074639

[14] Lin, F., Metter, E., O'Brien, R., Resnick, S., Zonderman, A., & Ferrucci, L. (2011). Hearing Loss and Incident Dementia. *Archives Of Neurology*, *68*(2). doi: 10.1001/archneurol.2010.362

[15] Reed, N., Altan, A., Deal, J., Yeh, C., Kravetz, A., Wallhagen, M., & Lin, F. (2019). Trends in Health Care Costs and Utilization Associated With Untreated Hearing Loss Over 10 Years. *JAMA Otolaryngology–Head & Neck Surgery*, *145*(1), 27. doi: 10.1001/jamaoto.2018.2875

[16] Supporting Success For Children With Hearing Loss | Brain Development & Hearing Loss. (2019). Retrieved from https://successforkidswithhearingloss.com/for-professionals/brain-development-hearing-loss/

services[17][18]. Most increased medical costs associated with hearing loss are a result of ineffective communication. Developing effective language in childhood results in a lifetime of savings in educational, healthcare, and disability related costs.

Educational and Disability Related Costs Extend Beyond Healthcare Costs

- The median reading level for deaf adults has long been 3rd grade, limiting access to health and safety information, job prospects, and other opportunities. [19]
- Deaf adults without adequate spoken language access face staggering unemployment rates [20].
- "The estimated cost in lost earnings due to untreated hearing loss is $122 billion while the cost to society in terms of unrealized Federal Taxes is $18 billion." [21]
- Children who receive both appropriate amplification and timely, qualified auditory oral services achieve language scores[22], literacy[23], and academic success comparable to hearing peers while

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[17] Goldblat, E., & Pinto, O. (2017). Academic outcomes of adolescents and young adults with hearing loss who received auditory-verbal therapy. *Deafness & Education International*, *19*(3-4), 126-133. doi: 10.1080/14643154.2017.1393604

[18] Ching, T., Dillon, H., Leigh, G., & Cupples, L. (2017). Learning from the Longitudinal Outcomes of Children with Hearing Impairment (LOCHI) study: summary of 5-year findings and implications. *International Journal Of Audiology*, *57*(sup2), S105-S111. doi: 10.1080/14992027.2017.1385865

[19] Qi, S., & Mitchell, R. (2011). Large-Scale Academic Achievement Testing of Deaf and Hard-of-Hearing Students: Past, Present, and Future. *Journal Of Deaf Studies And Deaf Education*, *17*(1), 1-18. doi: 10.1093/deafed/enr028

[20] Deaf Employment Reports. (2019). Retrieved from https://www.gallaudet.edu/research-support-and-international-affairs/research-support/research-resources/demographics/deaf-employment-reports

[21] (2019). Retrieved from http://hearingaidsterrehaute.com/uploads/MarkeTrak7_ImpactUntreatedHLIncome.pdf

[22] Rhoades, E. (2006). Research Outcomes of Auditory-Verbal Intervention: Is the Approach Justified?. *Deafness & Education International*, *8*(3), 125-143. doi: 10.1179/146431506790560157

[23] Robertson, C. (2019). Reading Development: A Parent Survey of Children with Hearing Impairment Who Developed Speech and Language through the Auditory-Verbal Method. Retrieved from https://eric.ed.gov/?id=EJ474410

educated in mainstream classrooms[24]. They no longer qualify for social security disability[25] and face better job prospects upon entering the workforce.

Cost of Hearing Aids

Hearing aids and the services to properly prescribe, evaluate, fit, and manage children with hearing loss generally cost an average of $3,500 per ear depending on the technology and enhancements selected by the audiologist based on the individual needs of the child. The associated costs to families of children with hearing loss include, for example, services for frequent adjustments; fittings of new ear molds necessary to accommodate the child's growth—up to 4 times per year for children until at least age 10 years; and, the on-going management required for children to assure their hearing aids are working optimally to maximize their ability to acquire communication and educational skills.

Today's hearing aids are complex computer programmed digital technology that must be individually fit to every child. They not only restore audibility based on individual needs but offer beneficial features such as noise and feedback management and various programs based on the listening environment. The hearing aids also feature wireless streaming permitting the child to audio-stream directly to the hearing aids as well as communicate with classroom and large group amplification systems, e.g., theaters, classrooms, churches.

The fitting process is validated by the audiologist using probe tube measurements of the child's ear canal and verification that the child is being properly amplified based on their individual needs and the individual anatomical and physiologic measurements of the child's auditory system. For young children, they must return to the audiologist at least monthly while adolescents may return to the audiologist quarterly.

(e) The level of public demand for the treatment or service.

See section A above.

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[24] Lim, S., Goldberg, D., & Flexer, C. (2018). Auditory-Verbal Graduates—25 Years Later: Outcome Survey of the Clinical Effectiveness of the Listening and Spoken Language Approach for Young Children with Hearing Loss. *The Volta Review*, *118*(1.2), 5-40. doi: 10.17955/tvr.118.1.2.790

[25] 2.00-Special Senses and Speech-Adult. (2019). Retrieved from https://www.ssa.gov/disability/professionals/bluebook/2.00-SpecialSensesandSpeech-Adult.htm

Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children

Prepared by The Florida Coalition for Spoken Language Options

(f) The level of public demand for insurance coverage of the treatment or service.

See section C above.

(g) The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.

Collective bargaining agents typically advocate for broader benefits than what is proposed in this bill. Collective bargaining agents for private insurance companies do not appear to have advocated specifically for the inclusion of this benefit in their health benefit packages.

(h) To what extent will the coverage increase or decrease the cost of the treatment or service.

Treatment services (hearing aids) should remain roughly the same; it is a small population that would fall into this coverage and should not impact the overall costs. Hearing aid costs range from practice to practice based on each practice's buying power from manufacturers and their sales model (which is why there is a range in cost). Passing of this bill should not change how much a service provider charges for their services and goods related to hearing aids.

(i) To what extent will the coverage increase the appropriate uses of the treatment or service.

There are no available studies to determine a specific amount of increase in appropriate use of hearing aids and their related services. It is believed that having coverage will increase the number of children using hearing aids and their related services.

(j) To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.

Having hearing aid coverage is not a substitute for any other treatment. Hearing loss would have to be so poor that a hearing aid would no longer work at which point a cochlear implant may be warranted. Taxpayers pay between $400,000 and $1,000,000 per child for untreated hearing loss. Cochlear implants as well as bone anchored devices are already covered by insurance companies. Both of those options are far greater in expense than hearing aids as they require surgery as well as the device.

Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children

Prepared by The Florida Coalition for Spoken Language Options

(k) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

Increases in insurance premiums resulting from The Florida Hearing Care for Children Act are estimated to be $0.056 PMPM and $0.68 per year for private insurance policies.

- Children benefiting from the FL Hearing Care for Children Act 1,709
- Total estimated number hearing aids:
  - Binaural (2) hearing aids: 1,623
  - Monaural (unilateral hearing loss) hearing aids 85
- Costs at $3500 per ear
  - Binaural $11,363,173
  - Monaural $ 299,031
  - Total costs $11,662,204
  - 2-year benefit $ 5,831,102
- Costs for Private Insurance Policies (based on 8,602,700 private insured)
  - Per member per month (PMPM) $0.056

(l) The impact of this coverage on the total cost of health care."

The proposed mandate is not expected to have a significant impact on total cost of healthcare in the state of Florida. The insurance companies will likely experience an increase in costs; however, the projected increase is negligible relative to the overall lifetime costs associated with children needing special education and loss of earning potential. The National Education Association estimates the average additional cost per special education student per year is $9,369. The CDC estimates that the cost for special education along with other direct nonmedical costs accounts for 24.3 percent of economic costs associated with hearing loss and that indirect costs such as lost economic productivity account for 69 percent of costs. A World Health Organization report in 2017 "shows that unaddressed hearing loss poses substantial costs to the health-care system and to the economy as a whole." The report further concludes that "provision of hearing devices is a cost-effective strategy, especially when used regularly and supported with rehabilitation services."

There is a preponderance of evidence supporting the positive effects and benefits of hearing aids and the Florida Hearing Care for Children Act. There is clear evidence in the literature demonstrating that

Impact of Senate Bill 1006: Insurance Coverage for Hearing Aids for Children

Prepared by The Florida Coalition for Spoken Language Options

fitting children with hearing aids is associated with greater gains in their development of speech and language. Risk for language delays in children with hearing loss may be mitigated from early age of fitting and consistent use of hearing aids.

The Florida Hearing Care for Children Act will benefit the families of children with hearing loss while assuring children will be provided with hearing aid technology that meets their educational and communication needs so that they can reach their full potential.

THE FLORIDA SENATE

COMMITTEES:
Ethics and Elections, *Chair*
Appropriations Subcommittee on Education
Education
Finance and Tax
Health Policy
Judiciary

JOINT COMMITTEE:
Joint Legislative Auditing Committee

SENATOR DENNIS BAXLEY
12th District

January 6, 2020

The Honorable Chair Doug Broxson
318 Senate Office Building
Tallahassee, Florida 32399

Dear Chair Broxson,

I would like to request that SB 1006 Insurance Coverage for Children with Hearing Aids be heard in the next Banking and Insurance Committee meeting.

This would require a health insurance policy that provides coverage on an expense-incurred basis for a member of the family of the insured must provide health insurance benefits that include coverage for children diagnosed with hearing loss from birth through 21 years of age for hearing aids prescribed, fitted, and dispensed by a licensed audiologist if the family member is a child between the ages of 0-21 years old or by a licensed hearing instrument specialist if the family member is age 18 years old or older.

An insurer must provide a minimum coverage amount of $3,500 per ear within a 24-month period. However, if a child experiences a significant and unexpected change in his or her hearing or a medical condition requiring an unexpected change in the hearing aid before the existing 24-month period has expired, and alterations to the existing hearing aid do not or cannot meet the needs of the child, a new 24-month period shall begin with full benefits and coverage. Also, the insured is responsible for the cost of hearing aids and related services that exceed the coverage provided by his or her policy.

Thank you for your favorable consideration.

Onward & Upward,

Senator Dennis K. Baxley
Senate District 12

DKB/dd

cc: James Knudson, Staff Director

320 Senate Office Building, 404 South Monroe St, Tallahassee, Florida 32399-1100 ● (850) 487-5012
Email: baxley.dennis@flsenate.gov

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/20/20
Meeting Date

SB 1006
Bill Number (if applicable)

Topic Coverage for Hearing Aids for Children
Amendment Barcode (if applicable)

Name Dr. Nancy Lawther

Job Title

Address 1747 Orlando Central Parkway
Street

Phone 407 855 7604

Orlando FL 32809
City *State* *Zip*

Email legislative@flapta.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida PTA

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

SB 1006
Bill Number (if applicable)

Topic Insurance for Hearing Aids

Amendment Barcode (if applicable)

Name Miranda Nerland

Job Title Parent Advocate - EHDI

Address 30441 Godfrey Pl
Street

Tallahassee FL 32309
City *State* *Zip*

Phone 813-415-4878

Email mirandaerland@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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

1-21-20
Meeting Date

SB-1006
Bill Number (if applicable)

Topic Hearing Aids - Children

Hearing
Amendment Barcode (if applicable)

Name Brian Nerland

Job Title

Address 3044 Godfrey Place
Street

Tallahassee FL 32309
City *State* *Zip*

Phone 813.841.6263

Email BdNerland@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

1006
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Hearing Aids

Name Mary Campbell Fiske

Job Title Student

Address 601 Grand Park
Street

St Johns 32259
City *State* *Zip*

Phone 706 941 2194

Email NA

Speaking: ☐ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

1006
Bill Number (if applicable)

Topic #SB 1006 Hearing Aids

Amendment Barcode (if applicable)

Name Michele Campbell

Job Title Mother

Address 120 Ivy Lakes Drive
Street

St. Johns FL 32259
City *State* *Zip*

Phone 904 704 7388

Email jmmcampbell0511@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing parents of children with hearing loss

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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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

1006
Bill Number (if applicable)

Topic Hearing Aids

Amendment Barcode (if applicable)

Name Harvey Rhinehart

Job Title Past Sertoma Governor

Address 14116 Marberry Way
Street

Odessa FL 33556
City *State* *Zip*

Phone 813-777-4852

Email hrjr@verizon.net

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Sertoma

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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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

SB 1006
Bill Number (if applicable)

Topic Hearing Aids For Children

Amendment Barcode (if applicable)

Name Mary-Lynn Cullen

Job Title Legislative Liaison

Address 1674 University Pkwy.
Street

Phone 941-928-0278

Sarasota FL. 34243
City *State* *Zip*

Email aichildren@aol.com

Speaking: ☒ For ☐ Against ☐ Information

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

Representing Advocacy Institute For Children

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

1006
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic #SB 1006 HEARING AIDS

Name ARCHIE CAMPBELL

Job Title FATHER

Address 120 IVY LAKES DR
Street

SAINT JOHNS FL 32259
City *State* *Zip*

Phone (904) 703-1512

Email archiecampbelljr@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FAMILIES OF CHILDREN WITH HEARING LOSS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

1006
Bill Number (if applicable)

Topic #SB 1006 Hearing Aid

Amendment Barcode (if applicable)

Name Debra Golinski

Job Title President / CEO Sertoma Speech & Hearing

Address 6333 River Road
Street

Phone 727-312-3881

New Port Richey FL 34652
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Sertoma Speech & Hearing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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1/21/20
Meeting Date

1006
Bill Number (if applicable)

Topic #SB 1006 HEARING AIDS

Amendment Barcode (if applicable)

Name WESTON CAMPBELL

Job Title BROTHER

Address 120 IVY LAKES DR
Street

Phone (904) 703-1512

SAINT JOHNS FL 32259
City *State* *Zip*

Email archiecampbellir@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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THE FLORIDA SENATE

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1/21/20
Meeting Date

1006
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Hearing Aid Bill

Name Theresa Bulger

Job Title Lobbyist

Address 1700 N Monroe St. Ste. 11 #182
Street

Phone 850 792 HEAR

Tallahassee FL 32303
City *State* *Zip*

Email tb@deafkids.com.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Academy of Audiologists / FL. Coalition / Clarke School

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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1/21/20
Meeting Date

1001p
Bill Number (if applicable)

Topic #SB 1001p Hearing Aids

Amendment Barcode (if applicable)

Name Addison Campbell

Job Title Sister

Address 120 Ivy Lake Drive
Street

St. Johns FL 32259
City *State* *Zip*

Phone 904-704-7388

Email mrscampbell0511@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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1/21/20
Meeting Date

1006
Bill Number (if applicable)

Topic SB1006 Hearing Aids

Amendment Barcode (if applicable)

Name Terri Fisk

Job Title Volunteer Parent President Florida Coalition for Spoken Language Options

Address 601 Grand Parke Dr
Street

Phone 706-941-2194

St. Johns, FL 32259
City *State* *Zip*

Email TFisk@deafkidscan.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Coalition for Spoken Language Options

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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THE FLORIDA SENATE

APPEARANCE RECORD

1/21/20 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 1006

Meeting Date *Bill Number (if applicable)*

Topic HEARING AIDS *Amendment Barcode (if applicable)*

Name Knox Fisk

Job Title Deaf Child

Address 601 Grand Parke Dr Phone 706-941-2194
Street

St. Johns FL 32259 Email
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Deaf Children

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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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

1006
Bill Number (if applicable)

Topic Coverage for Hearing Aids for Children

Amendment Barcode (if applicable)

Name Stephen Winn

Job Title Lobbyist

Address 2544 Blairstone Pines Dr.
Street

Phone 850-878-7364

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 Society of Hearing Healthcare Professionals

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

1006
Bill Number (if applicable)

Topic Hearing Aids

Amendment Barcode (if applicable)

Name Garrett Campbell

Job Title Student

Address 120 Ivy Lakes Drive
Street

Phone 904-293-6890

St. Johns Florida 32259
City *State* *Zip*

Email gkcampbell0620@gmail

Speaking: ☒ For ☐ Against ☐ Information

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

Representing SELF

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

1-21-20 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 1006

Meeting Date *Bill Number (if applicable)*

Topic Coverage for hearing AIDS *Amendment Barcode (if applicable)*

Name Jarrod Fowler

Job Title Dir. of Health Care Policy

Address 1430 Piedmont Dr. E Phone 850-224-6496

Street

Tallahassee FL 32308 Email Howler@flmedical.org

City *State* *Zip*

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

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

Representing Florida Medical Association

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

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1224
INTRODUCER:	Senator Simmons
SUBJECT:	Real Estate Conveyances
DATE:	January 17, 2020
REVISED:	

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

I. Summary:

SB 1224 provides that a written leasehold estate in real property with a term of more than 1 year does not require subscribing witnesses. Currently, two subscribing witnesses are required.

II. Present Situation:

Execution of a Lease with a Term Greater Than 1 Year

Section 689.01, F.S., requires that the sale of real property, or the leasing of real property for a term of more than 1 year, must be conveyed by a written instrument that is signed by the party conveying the real property, or the party's authorized agent, in the presence of two subscribing witnesses. The subscribing witness requirement provides evidence that the instrument contains the actual signature of the person conveying the property.

In 2019 the Legislature amended s. 689.01, F.S., to provide that the requirement that the instrument conveying property be signed in the presence of two subscribing witnesses may be satisfied by witnesses being present and electronically signing by means of audio-video communication technology.[1]

Chapter 692, F.S., provides to corporations an alternative method of conveying real property through a sale or lease. A corporation may instead execute a document sealed with the common or corporate seal that is signed in its name by the president, vice-president, or chief executive officer. This alternative method may not be used by other forms of business organizations such as a limited liability company (LLC).[2]

[1] Chapter 2019-71, s. 21, L.O.F.

[2] Skylake Ins. Agency v. NMB Plaza, LLC, 23 So. 3d 175 (Fla. 3rd DCA 2009).

III. Effect of Proposed Changes:

Section 1. Amends s. 689.01(1), F.S., to provide that a written leasehold estate in real property does not require subscribing witnesses. Currently, two subscribing witnesses are required.

Section 2. This act takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 689.01 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Simmons

9-01300-20 20201224__

A bill to be entitled

An act relating to real estate conveyances; amending s. 689.01, F.S.; providing that subscribing witnesses are not required to validate certain instruments conveying a leasehold interest in real property; providing an effective date.

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

Section 1. Subsection (1) of section 689.01, Florida Statutes, is amended to read:

689.01 How real estate conveyed.—

(1) No estate or interest of freehold, or for a term of more than 1 year, or any uncertain interest of, in, or out of any messuages, lands, tenements, or hereditaments shall be created, made, granted, transferred, or released in any ~~other~~ manner other than by instrument in writing, signed in the presence of two subscribing witnesses by the party creating, making, granting, conveying, transferring, or releasing such estate, interest, or term of more than 1 year, or by the party's lawfully authorized agent, unless by will and testament, or other testamentary appointment, duly made according to law; and no estate or interest, either of freehold, or of term of more than 1 year, or any uncertain interest of, in, to, or out of any messuages, lands, tenements, or hereditaments, shall be assigned or surrendered unless it be by instrument signed in the presence of two subscribing witnesses by the party so assigning or surrendering, or by the party's lawfully authorized agent, or by the act and operation of law; provided, however, that no

9-01300-20 20201224__

subscribing witnesses shall be required for any such instrument pertaining to a leasehold estate in real property. No seal shall be necessary to give validity to any instrument executed in conformity with this section. Corporations may execute any and all conveyances in accordance with the provisions of this section or ss. 692.01 and 692.02.

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

The Florida Senate

Committee Agenda Request

To: Senator Doug Broxson, Chair
Committee on Banking and Insurance

Subject: Committee Agenda Request

Date: January 10, 2020

I respectfully request that **Senate Bill 1224**, relating to Real Estate Conveyances, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator David Simmons
Florida Senate, District 9

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21/20
Meeting Date

1224
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Property Leases

Name Chris Carmody

Job Title Attorney

Address 301 E. Pine St., 1400
Street
Orlando FL 32801
City *State* *Zip*

Phone

Email

Speaking: ☒ For ☐ Against ☐ Information

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

Representing NAIOP 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)

1224
~~1244~~

1/21/2020
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Real Estate Conveyances

Name Greg Black

Job Title Lobbyist

Address 1727 Highland Pl
Street

Phone 509-8022

TLH FL 32308
City *State* *Zip*

Email greg@waypointstrat.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing International Council of Shopping Centers

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

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 1338
INTRODUCER:	Senator Wright
SUBJECT:	Prescription Drug Coverage
DATE:	January 17, 2020
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

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

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

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

- Clarifies that the Office of Insurance Regulation has the authority to conduct market conduct examinations of PBMs to determine compliance with the provisions of the code.
- Requires insurers or HMOs, and their PBMs to comply with the pharmacy audit provisions, and provides authority for the OIR to enforce these provisions.
- Provides that a pharmacy may appeal audit findings, relating to the payment of a claim or the amount of a claim payment, through the Statewide Provider and Health Plan Claim dispute Resolution Program under the Agency for Health Care Administration.

- Clarifies that an insurer or HMO remains responsible for any violations of the prompt pay law by a PBM acting on its behalf.
- Clarifies the OIR's authority to review contracts that an insurer has with a PBM, authorizes OIR to review reasonableness of PBM fees, and allows the OIR to order the cancellation of such contracts under certain conditions. Currently, the OIR has the authority to review HMO contracts to review the reasonableness of fees and cancel such contracts if fees are not reasonable.
- Revises definitions and clarifies the OIR's authority if PBMs acting on behalf of insurers or HMOs do not comply with specified provisions.
- Revises the definition of the term, "maximum allowable cost;" and creates definitions of the terms, "brand drug," and "generic drug."
- Requires PBMs to pass through generic rebates to an insurer or HMOs.
- Increases PBM transparency by requiring the submission of an annual report to the OIR regarding rebates and other information.

According to the PBM for the State Group Insurance program, the fiscal impact of the bill would result in an increase in plan cost of $8.82 million, which is $2.05 per member per month or $24.57 per member per year. There would be an increase in total member cost of $1.7 million.

II. Present Situation:

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

Many public and private employers and health plans contract with a pharmacy benefit manager (PBM) to help control drug costs. While PBMs provide pharmacy claims processing and mail-order pharmacy services to their customers, many provide additional services, including rebate negotiations with drug manufacturers, development of pharmacy networks, formulary management, prospective and retrospective drug utilization reviews, generic drug substitutions, and disease management programs. The PBM generally manages the list of preferred drug products (formulary) for each of its plan sponsors.

The affordability of prescription drugs has gained attention at the state and federal level. In recent years, PBMs and drug manufacturers have come under scrutiny as policymakers have attempted to understand their role in the drug supply chain. Several entities are involved with, and pay different prices for, prescription drugs as they move from the drug manufacturer to the insured (a system referred to as the drug supply chain). In general, manufacturers develop and sell their drugs to wholesalers, and wholesalers then sell the drugs to pharmacies. The PBMs

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

may perform functions such as designing drug formularies, negotiating prices, and administering prescription payments.

In 2018, three companies processed about 75 percent of all equivalent prescription claims: CVS Health (including Caremark and Aetna), Express Scripts, and the OptumRx business of UnitedHealth. The top six PBMs handled more than 95 percent of the total U.S. equivalent prescription claims managed.[2] The top six PBMs were:

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

The decision of employers, HMOs, or insurers to contract with PBMs to control pharmacy benefit costs, however, may shift business away from smaller, independent retail pharmacies. Historically, independent pharmacies were important health care providers in their communities and their pharmacists had long-term relationships with their patients.[3] However, many independent pharmacies have closed in recent years because of the competition resulting from the proliferation of large, chain retail pharmacies[4] that can negotiate with PBMs at deeply discounted reimbursement levels based on large volume sales.

Contracts between PBMs and health plan sponsors specify how much the health plan sponsors will pay PBMs for brand name and generic drugs. These prices are typically set as a discount off the average wholesale price (AWP)[5] for brand-name drugs and at a maximum allowable cost (MAC)[6] for generic drugs (and sometimes brand drugs that have generic versions), plus a dispensing fee. The MAC represents the upper limit price that a plan will pay or reimburse for generic drugs and sometimes brand drugs that have generic versions available (multisource brands). A MAC pricing list creates a standard reimbursement amount for identical products. A MAC pricing list is a common cost management tool that is developed from a proprietary survey of wholesale prices existing in the marketplace, taking into account market share, inventory, reasonable profit margins, and other factors.

The purpose of the MAC pricing list is to ensure that the pharmacy or their buying groups are motivated to seek and purchase generic drugs at the lowest price in the marketplace. If a pharmacy procures a higher-priced product, the pharmacy may not make as much profit or in some instances may lose money on that specific purchase. If a pharmacy purchases generic drugs at a more favorable price, they will be more likely to make a profit.

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[2] Drug Channels, CVS, Express Scripts, and the Evolution of the PBM Business Model (May 29, 2019) at https://www.drugchannels.net/2019/05/cvs-express-scripts-and-evolution-of.html (last viewed Jan. 10, 2020).

[3] Independent pharmacies are a type of retail pharmacy with a store-based location—often in rural and underserved areas—that dispense medications to consumers, including both prescription and over-the-counter drugs. See http://www.gao.gov/assets/660/651631.pdf (last viewed Mar. 1, 2017).

[4] Such as Walmart, CVS, Walgreens, Publix or Kroger.

[5] AWP is the retail list price (sticker price) or the average price that manufacturers recommend wholesalers sell to physicians, pharmacies and others, such as hospitals.

[6] MAC is a price set for generic drugs and is the maximum amount that the plan sponsor will pay for a specific drug.

Independent Pharmacies

Nationwide, the number of independent pharmacies in the United States continues to decline. In 2010, there were 23,106 independent pharmacies; by 2017, that number had dropped to 21,909.[7] Another report[8] noted that the number of independent retail pharmacies in Florida increased 32.4 percent from 2010 to 2019. During that same period, the number of independent retail pharmacists peaked in 2017 at 1,735, and declined to 1,541 in 2019. The number of chain pharmacies increased 2.2 percent for the same period.[9] Pharmacists cite problems relating to PBMs extracting fees from community pharmacies months after a transaction rather than deducting them from claims on a real-time basis. These retroactive clawbacks make it challenging to operate small businesses when the pharmacists do not know if they will break even on a transaction until months later. The pharmacists also cite the competition from mail-order or brick and motor affiliates as another problem and note that PBMs provide incentives for insureds, through copayments, incentives, and limitations on refill supplies, to use their network affiliates.

A Study of 15 Large Employer Plans[10]

A recent report noted that large employers and other plan sponsors are concerned about addressing the rising cost of drugs. The report evaluated drug utilization from 15 self-insured plan sponsors to estimate savings from reducing the use of high cost, low-value drugs and described some of the cost concerns relating to the drug supply chain, as follows:

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

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

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[7] Arnold, Karen, *independent Pharmacies: Not Dead Yet,* (Jan. 12, 2019) at http://www.drugtopics.com/article/independent-pharmacies-not-dead-yet (last viewed Oct. 23, 2019).
[8] Quest Analytics analysis of NCPDP Pharmacy Count Data, 2019. Provided by PCMA. On file with Banking and Insurance Committee.
[9] *Id.*
[10] Vela, Lauren, *Reducing Wasteful Spending in Employers' Pharmacy Benefit Plans*(Aug. 2019) the Commonwealth Fund at https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/reducing-wasteful-spending-employers-pharmacy-benefit-plans (last viewed Jan. 3, 2020).

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

Regulation of Health Insurance in Florida

The Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities.[11] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[12] The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[13] As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[14]

Section 641.234, F.S., authorizes the office to require a HMO to submit any contract for administrative services, contract with a provider other than an individual physician, contract for management services, and contract with an affiliated entity to the OIR. After review of a contract the OIR may order the HMO to cancel the contract in accordance with the terms of the contract and applicable law if it determines:

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

Oversight of PBMs

Registration. A PBM is as a person or entity doing business in Florida, which contracts to administer prescription drug benefits on behalf of a health insurer or a HMO to residents of Florida.[15] In 2018, legislation was enacted to require PBMs to register with the OIR, effective January 1, 2019.[16] The registration process requires a nonrefundable fee not to exceed $500,

[11] Section 20.121(3)(a)1., F.S.
[12] Section 641.21(1), F.S.
[13] Section 641.49, F.S.
[14] Section 641.495, F.S.
[15] Section 624.490, F.S.
[16] Section 3, ch. 2018-91, L.O.F.

submission of a copy of certain corporate documents, and a completed registration form. Registration and registration renewal certificates are valid for 2 years and are nontransferable.[17] Registrants must report any change in the registration information within 60 days of the change to the OIR.

Maximum Allowable Cost and Contract Provisions. The term, "maximum allowable cost" (MAC) is the per-unit amount that a PBM reimburses a pharmacist for a prescription drug, excluding dispensing fees, prior to the application of copayments, coinsurance, and other cost-sharing charges, if any.[18]

The law also repealed provisions in the Florida Pharmacy Act, s. 465.1862; F.S., relating to PBM contracts, and transferred them to the insurance code.[19] These provisions require contracts between health insurers or HMOs and PBMs to require the PBM to:

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

However, the bill did not provide the OIR with enforcement authority over PBMs to ensure compliance with these contractual provisions, such as being able to revoke or suspend a PBM's registration or fine the PBM. Therefore, when the OIR is addressing any statutory violations by a PBM, the OIR would look to the insurer or HMO, which contracts with the PBM to fulfill its obligations under the insurance code to resolve the situation.[20]

Payment of claims. Section 627.6131, F.S., requires a PBM, acting on behalf of an insurer or HMO to pay a provider's claim within a prescribed time.

Florida Pharmacy Act

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

- To be notified at least 7 calendar days before the initial onsite audit.
- To have the onsite audit scheduled after the first 3 calendar days of a month unless the pharmacist consents otherwise.

[17] Section 624.490, F.S.
[18] Sections 627.64741, 627.6572, and 641.314, F.S.
[19] Sections 627.64741, 627.6572, and 641.314, F.S.
[20] Office of Insurance Regulation, *2020 Legislative Analysis of SB 1338* (Jan. 2, 2020).

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

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

State Group Insurance Program

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

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

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

prescribers, the PBM's specialty pharmacies have clinicians trained in each of the clinical disciplines, conditions, and specialties corresponding to the specialty drugs being dispended.

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

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

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

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

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

Statewide Provider and Health Plan Claim Dispute Resolution Program

The intent of this program, administered by the Agency for Health Care Administration (agency), is to provide assistance to contracted and noncontracted providers and health plans for resolution of claim disputes that are not resolved by the provider and the health plan.[21] The agency contracts with an independent dispute resolution organization to provide assistance to health care providers and health plans in order to resolve claim disputes. These services are available to Medicaid managed care providers and health plans. Claims submitted to managed care plans that have been denied in full or in part, or allegedly underpaid or overpaid may be eligible for dispute under the arbitration process.[22]

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

Insurers, HMOs, and PBMs

Health insurers and HMOs are required to report how much they spend on health care and how much they spend on administrative costs, such as salaries and marketing. If an insurer or HMO

[21] Section 408.7057, F.S.
[22] *Id.*

spends less than 80 percent (85 percent in the large group market) of premium on medical care and efforts to improve the quality of care, they must refund the portion of premium that exceeds this limit. The 80 percent (or 85 percent) is the medical loss ratio. The PBMs must report rebate information to the health insurers and HMOs, and the insurer or HMO includes this information as a deduction from the amount of incurred claims in the MLR reporting to the Department of Health and Human Services (HHS).[23] The Medicaid plans must also calculate and report medical loss ratios, which must account for rebates and spread pricing, as described below.

Medicaid

According to the Centers for Medicare and Medicaid Services (CMS), states are increasingly reporting instances of spread pricing in Medicaid, including cases in Ohio and Texas, and CMS is concerned that spread pricing is inflating prescription drug costs that are borne by beneficiaries and by taxpayers.[24] Further, if spread pricing is not monitored, a PBM can profit from charging health plans an excess amount above the amount paid to the pharmacy dispensing a drug, which increases Medicaid costs for taxpayers.

According to CMS, spread pricing has been reported predominantly for generic prescriptions. States have raised concerns that PBMs can reimburse pharmacies for generic prescriptions based on lower pricing benchmarks than the benchmarks used for charging Medicaid and CHIP managed care plans for the same prescriptions.

In response to these concerns, the Centers for Medicare and Medicaid Services (CMS) released guidance that prohibits PBMs using spread pricing to upcharge health plans and increase costs for states.[25] For purposes of the medical loss ratio[26] (MLR) regulation, "prescription drug rebates" means any price concession or discount received by the managed care plan or by its PBM, regardless of who pays the rebate or discount.[27] Some possible examples include payments from pharmaceutical manufacturers, wholesalers, and retail pharmacies. Therefore, the amount retained by a PBM under spread pricing would have to be excluded from the amount of claims costs used for calculating the Medicaid managed care plan's MLR. The policy underlying this guidance is that spread pricing should not be used to artificially inflate a Medicaid or CHIP managed care plan's MLR. For purposes of calculating the medical loss ratio, the Medicaid managed care regulations[28] require that prescription drug rebates received and accrued must be deducted from incurred claims. The CMS also interprets this requirement to apply equally regardless of whether the prescription drug rebate is received by the managed care plan (i.e.,

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[23] Section 2718 of the Public Health Service Act. The HHS has the authority to examine insurers and HMOs and their venders, such as PBMs, regarding data and the timeliness of submissions.

[24] Centers for Medicare and Medicaid Services, *CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers* (May 15, 2019) at https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not (last viewed Jan. 3, 2020).

[25] Centers for Medicare and Medicaid Services, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors* (May 15, 2019) https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf (last viewed Jan. 3, 2020).

[26] CMS regulations require Medicaid and CHIP managed care plans to report an MLR and use an MLR target of 85 percent in developing rates. The 85 percent target means that only 15 percent of the revenue for the managed care plan can be used for administrative costs and profits.

[27] 42 CFR 438.8(e)(2)(ii)(B).

[28] *Id.*

directly) or by a subcontractor (i.e., indirectly) administering the covered outpatient drug benefit on behalf of the managed care plan.

When a managed care plan subcontracts with a third-party vendor to administer, and potentially provide, a portion of Medicaid covered services to enrollees, the subcontractor must report to the managed care plan all of the underlying data needed for the Medicaid managed care plan to calculate and report the managed care plan's MLR.[29] The regulations at 42 CFR 438.8(k) also require states, through their contracts with managed care plans, to require each managed care plan to submit an annual MLR report.

Drug Pricing Transparency

Due to a lack of transparency in the marketplace, it can be difficult to determine the final price of a prescription drug. Drug companies price discriminate, meaning they sell the same drug to different buyers (wholesalers, health plans, pharmacies, hospitals, government purchasers, and other providers) at different prices. The final price of a drug may include rebates and discounts to health plans and pharmacy benefit managers that are not disclosed. Market participants, such as wholesalers, add their own markups and fees. Drug manufacturers may offer direct consumer discounts, such as prescription drug coupons that can be redeemed when filling a prescription at a pharmacy.

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

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

Federal

Medicare Part D plans and qualified health plan issuers who have their own PBM or contract with a PBM are required to report to the U.S. Department of Health and Human Services (HHS) aggregate information about rebates, discounts, or price concessions that are passed through to the plan sponsor or retained by the PBM. In addition, the plans must report the difference between the amount the plan pays the PBM and the amount that the PBM pays its suppliers (spread pricing). The reported information is confidential, subject to certain limited exceptions. [30]

State Level

In 2016, Vermont approved the first law requiring manufacturer disclosure for drugs that underwent large percentage price increases.[31] Each year, this law requires state regulators to

[29] 42 CFR 438.230(c)(1) and 42 CFR 438.8(k)(3).
[30] 42 U.S.C. s. 1320b-23.
[31] *See* https://legislature.vermont.gov/Documents/2016/Docs/ACTS/ACT165/ACT165%20Act%20Summary.pdf (last viewed Jan. 11, 2020).

compile a list of 15 drugs used by Vermont residents that experience the largest annual price increases. Manufacturers are required to justify the price increase to the Attorney General. The act requires the Attorney General to provide an annual report to the General Assembly based on the information the Office receives from manufacturers and to post the report on the Office's website.

Oregon established a "fair pricing" legislative task force in 2018 (HB 4005) that has developed more than a dozen recommendations for further work, including state agency reporting on the 10 most expensive drugs and the 10 with the highest price increases; manufacturer justification of high prices; insurer explanation of formulary practices; provider disclosure of markups; and evaluation of PBM rebates. Maine also enacted a law in 2018 (LD 1406) requiring the state's APCD to annually report on the price of the state's most frequently prescribed and costliest prescription drugs, and to develop a plan for the collection of cost and pricing information from drug manufacturers.[32]

The California Drug Pricing Reporting Law (the law)[33] is designed to provide greater information about trends and factors relating to drug cost and pricing for policymakers and the public. The law imposes price justification, notification, and reporting requirements on pharmaceutical manufacturers for price increases on their drugs sold to state purchasers, insurers, and pharmacy benefit managers in California. The law requires manufacturers to notify state regulators regarding price increases, too. Further, the law requires insurers and health maintenance organizations to report specified cost information regarding covered prescription drugs and the impact of such cost on premiums. The state is required to compile such information and post the annual report on its website. The state may impose civil penalties against entities failing to comply with the reporting requirements. The law requires manufacturers to provide written notification to:

- Purchasers (insurers, HMOs, pharmacy benefit managers, and state agencies) of a drug price increase that exceeds 16 percent over a 2-year period for any drugs with a wholesale acquisition cost (WAC)[34] of greater than $40. The notice must include a statement regarding whether a change or improvement in the drug necessitates the price increase, and if applicable, a description of such change or improvement. This notification must be provided at least 60 days prior to the effective date of the increase.
- The state for each drug for which an increase in WAC, as described above, occurs, or other specified drug price increases. Manufacturers must provide information regarding such drug's indication and dosage, factors used to increase the WAC, and marketing materials.

[32] Ario, Joel, *Strategies to Expand Transparency, Enhance Competition and Control Costs: A Toolkit for Insurance Regulators Manatt Health Strategies* (Jul. 2019) at https://www.naic.org/meetings1908/cmte_b_health_inn_wg_2019_summer_nm_materials_strategies.pdf (last viewed Jan. 3, 2020).

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

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

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

III. Effect of Proposed Changes:

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

Section 2 transfers s. 465.1885, F.S., to s. 624.491, F.S., and amends the section to clarify existing requirements and limitations for pharmacy audits by an insurer or HMO or an entity on behalf of the insurer or HMO, including but not limited to a PBM, are specified in the bill such as in areas relating to:

- Limits on when audits can be conducted;
- Audit scope;
- Use of a consulting pharmacist;
- Use of written and verifiable records of health care providers to validate pharmacy records;
- Retroactive reimbursement for claims denied for certain errors;
- The timeframe for the provision of preliminary audits;
- Allowance for production of preliminary documentation to rebut an audit finding;
- Time period for production of the final audit;
- How final recoupment and penalties are calculated.

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

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

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

- If the health insurer or HMO contracted with a PBM, the aggregate amount of the difference between the amount the health insurer or HMO paid the PBM and the amount the PBM paid retail pharmacies and mail order pharmacies.

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

The bill defines "brand name drug" as a drug described by the Medi-Span Master Drug Database and has a multi-source code containing an "M" an "O" or an "N" except for a drug with a multi-source code of "O" and "Dispense as Written code" of 3, 4, 5, 6, or 9; or, the drug has an equivalent brand drug designation in the First Database FDB MedKnowledge database.
The Medi-Span Master Drug Database is drug information database and analytics tool of Wolters Kluwer.[35] The database provides prescription and over the counter drug prices, drug dosing and strengths, and National Drug Code or Canadian Drug Identification numbers. The FDB MedKnowledge database is also a drug information tool for resources for medication adherence, drug alert management, drug utilization review, and medication reconciliation.[36]

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

"Maximum Allowable Cost" is modified to specify the per unit amount that is reimbursed to the pharmacy benefit manager for prescription drugs is the amount specified at the time of claim processing and directly or indirectly reported on the initial remittance advice of an adjudicated claim for a generic drug, a brand name drug, biological product, or a specialty drug. Additionally, the reimbursement amount must be based on the pricing published in the Medi-Span Master Drug Database or, if the pharmacy only uses the First Databank FDB Medknowledge, the pricing must be based on the price published in First Databank FDB Medknowledge.

Drugs that are identified as brand name drugs must be considered brand name drugs for all purposes under an agreement, contract, or amendment between insurers, an HMO, and a PBM or a pharmacy services organization on behalf of a pharmacy. A single source generic drug is also considered a brand name drug for these purposes. A drug identified as a generic drug must be considered a generic drug for all purposes under an agreement, contract, or amendment between insurers, a HMO, and a PBM or a pharmacy services organization on behalf of a pharmacy. A PBM and the pharmacy, or a pharmacy services administrative organization on behalf of the pharmacy shall agree that any rebate or other financial benefit for a generic drug is provided to the PBM that the PBM shall only serve as a pass-through to the health insurer or HMO.

Further, the section prohibits a health insurer or HMO from contracting with a PBM that:
- Does not update its maximum allowable cost pricing information at least every 7 days.

[35] Wolters Kluwer, *Medi-Span Electronic Drug (MED-File) v2, https://www.wolterskluwercdi.com/drug-data/medi-span-electronic-drug-file/* (last viewed January 15, 2020).
[36] First Databank, at https://www.fdbhealth.com/ (last viewed January 15, 2020).

- Does not maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.
- Limits a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug.
- Requires an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of the applicable cost-sharing amount or the retail price in the absence of prescription drug coverage.

The section also provides that the OIR may require any health insurer or HMO to submit any PBM contract or amendment for the administration of pharmacy benefits to the office for review. After review of the contract, the office may order the health insurer or HMO to cancel the contract in accordance with the contract terms and applicable law if the following conditions exist:

- The PBM fees paid by the health insurer or HMO are unreasonably high compared to similar contracts entered by health insurers or HMOs, or as compared to similar contracts in similar circumstances, that the contract is detrimental to the policyholders or subscribers of the insurer or HMO.
- The contract does not comply with the Florida Insurance Code.
- The PBM is not registered with the Office of Insurance Regulation pursuant to s. 624.490, F.S.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will provide pharmacies an opportunity to appeal PBM audit filings relating to claim payments with the Statewide Provider and Health Plan Claim Dispute Resolution Program.

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

C. Government Sector Impact:

Office of Insurance Regulation

The OIR will need to obtain pharmacy-related training and/or a contract with a pharmacist in order to provide effective oversight of PBM market conduct examinations and respond to any complaints involving pharmacy audits. The minimum estimated cost to contract with a pharmacist would be $100,000 - $200,000 (contracted services).[37]

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

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

- MONY definitions to define the Brand and Generic drugs based on claims utilization for January – December 2019.
- For all the drugs that changed from Brand to Generic, CVS Caremark determined what the price would have been and compared it to the current paid claims and did the same for the Generic to Brand drugs.
- There are approximately 70K claims that would change from Generic to Brand under the MONY definitions. All these claims would now be at the Brand rates and members would have to pay the Brand copays.
- There are approximately 3,000 claims that would change from Brand to Generic under the MONY definitions. All these claims would now be at the Generic rates and members would pay the Generic copays.

The plans serving the State Group Insurance program responded that the bill had no fiscal impact.

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

VI. Technical Deficiencies:

Sections 4, 5, and 6 include several terms, which are not defined and could cause confusion or lack of uniformity if a common description is not agreed upon. Some examples of the terms include pharmacy services administrative organization, rebate, and other financial benefit.

VII. Related Issues:

The current PBM contract for DSGI is scheduled for re-procurement during the 2020 calendar year with a proposed effective date of January 1, 2021.

VIII. Statutes Affected:

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

This bill creates section 624.491 of the Florida Statutes.

This bill repeals section 465.1885 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

632656

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

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

632656

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

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

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

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

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

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read:

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

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

And the title is amended as follows:

Between lines 2 and 3

insert:

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

275668

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete lines 146 - 148
and insert:
Section 3. Section 624.492, Florida Statutes, is created to read:
624.492 Health insurer, health maintenance organization,

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

275668

Delete line 15

and insert:

624.492, F.S.; providing applicability; requiring

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LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Between lines 510 and 511
insert:

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

627.444 Health insurers; prescription drug spending reports.—

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

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

422030

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

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

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

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

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

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

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

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

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

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

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any health insurer's proprietary or confidential information.

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

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

641.262 Prescription drug spending reports.—

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

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

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

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

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

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

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

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

(e) Any premium reduction that was attributable to

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specialty drug utilization management.

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

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

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

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

And the title is amended as follows:

Between lines 39 and 40

insert:

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

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authorizing the commission to adopt rules;

By Senator Wright

14-01655-20 20201338__

A bill to be entitled

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

14-01655-20 20201338__

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

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

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

624.3161 Market conduct examinations.—

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

(3) The examination may be conducted by an independent

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to:

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

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

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

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

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

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

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

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

(1) This section applies to:

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

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

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

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

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

organization, or pharmacy benefit manager under the contract.

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

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

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

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

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

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

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

627.64741 Pharmacy benefit manager contracts.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

exceeds the lesser of:

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

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

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

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

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

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

the office determines that any of the following conditions exist:

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

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

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

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

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

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

627.6572 Pharmacy benefit manager contracts.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

read:

641.314 Pharmacy benefit manager contracts.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

following conditions exist:

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

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

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

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

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

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Military and Veterans Affairs and Space, *Chair*
Children, Families, and Elder Affairs
Commerce and Tourism
Environment and Natural Resources

JOINT COMMITTEE:
Joint Administrative Procedures Committee

SENATOR TOM A. WRIGHT
14th District

January 8, 2020

The Honorable Doug Broxson
318, Senate Office Building
404 S. Monroe Street
Tallahassee, FL 32399

Re: Senate Bill 1338 – Prescription Drug Coverage

Dear Chair Broxson:

Senate Bill 1338, relating to Prescription Drug Coverage has been referred to the Committee on Banking and Insurance. I am requesting your consideration on placing SB 1338 on your next agenda. Should you need any additional information please do not hesitate to contact my office.

Thank you for your consideration.

Sincerely,

Tom A. Wright

Tom A. Wright, District 14

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

REPLY TO:
❒ 4606 Clyde Morris Blvd., Suite 2-J, Port Orange, Florida 32129 (386) 304-7630
❒ 312 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5014

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

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 1376
INTRODUCER:	Senator Broxson
SUBJECT:	Credit For Reinsurance
DATE:	January 17, 2020
REVISED:	

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

I. Summary:

SB 1376 provides insurers with credit for reinsurance and eliminates additional collateral requirements for reinsurers if the reinsurer is domiciled in a "reciprocal jurisdiction" and meets requirements set forth in the bill including, but not limited to:

- Minimum capital and surplus requirements;
- Minimum solvency or capital ratio;
- The domiciliary supervisory authority provides annual confirmation that the reinsurer meets the capital, surplus, and minimum solvency or capital ratio requirements; and
- Prompt claims payment practices.

The bill defines a reciprocal jurisdiction as:

- A non-US jurisdiction that is subject to an in-force covered agreement[1] with the US or, in the case of a covered agreement between the United States and the European Union,[2] an EU member state;
- A US jurisdiction that meets the NAIC's requirements for accreditation; or
- Any other qualified jurisdiction that meets the OIR's requirements as set forth in rule.

The bill also provides insurers protections against reinsurer failure that include, but are not limited to, requiring the reinsurer to post collateral equal to all outstanding reinsurance liabilities in the event the reinsurer enters into receivership; requiring the reinsurer to consent to the jurisdiction of courts of the State of Florida; and requiring the reinsurer to post collateral equal to

[1] The bill defines a "covered agreement" to mean an agreement entered into pursuant 31 U.S.C ss. 313 and 314 (The Dodd-Frank Wall Street Reform and Consumer Protection Act) which is effective or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

[2] The United States entered into such an agreement on September 22, 2017, the Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.

all outstanding liabilities if the reinsurer resists enforcement of a court order from a jurisdiction in which it has consented.

The bill's revisions to Florida law governing credit for reinsurance enact 2019 revisions to the National Association of Insurance Commissioners (NAIC) Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786).

The bill takes effect July 1, 2020.

II. Present Situation:

Reinsurance

Reinsurance is a contract of indemnity between commercial parties whereby the assuming insurer (reinsurer) agrees, for a portion of the premium, to compensate the ceding insurer for all or part of the losses and loss adjustment expenses incurred by the ceding insurer (insurer) under insurance policies issued by the insurer to its policyholders.[3] Through the reinsurance contract, the insurer reduces its probable maximum loss on either an individual risk (facultative reinsurance) or a specific class of insurance policies (treaty reinsurance) by ceding a portion of its liability to the reinsurer.[4] Reinsurance serves to (1) increase underwriting capacity; (2) stabilize underwriting results; (3) protect against catastrophic losses; (4) finance expanding volume; (5) withdraw from a class or line of business, or a geographic area, within a short time period; and (6) share large risks with other companies.[5] Reinsurers may in turn further spread their assumed risk by purchasing reinsurance protection, which is called retrocession.[6]

Reinsurance creates privity of contract between the insurer and reinsurer, and does not modify the insured's policy with its insurer.[7] Therefore, the reinsurance contract does not discharge the insurer from its primary liability to its policyholders or its obligation to pay policyholder claims.[8] Similarly, only the insurer has direct rights to recover from the reinsurer unless expressly provided for in the reinsurance contract.[9]

Florida regulates reinsurance under s. 624.610, F.S., and 69O-144, F.A.C.

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[3] https://content.naic.org/consumer_glossary.htm#R (last visited January 13, 2020).
[4] Barron's Dictionary of Insurance Terms, 437 (6th ed. 2013).
[5] *Id*.
[6] https://content.naic.org/cipr_topics/topic_reinsurance.htm (last visited January 13, 2020).
[7] US Department of Treasury, Federal Insurance Office, *The Breadth and Scope of the Global Reinsurance Market and the Critical Role Such Market Plays in Supporting Insurance in the United States* (December 2014), https://www.treasury.gov/initiatives/fio/reports-and-notices/Documents/FIO%20-Reinsurance%20Report.pdf (last visited January 13, 2020).
[8] *Id*.
[9] *Morris & Co. v. Skandinavia Ins. Co.*, 279 U.S. 405, 408 (1929); *Citizens Cas. Co. v. Am. Glass. Co.*, 166 F.2d 91, 95 (7th Cir. 1948).

Regulation of Reinsurance

The United States (US) is both the largest insurance market and reinsurance market in the world by premium volume.[10] Furthermore, roughly half of all business originates from North America.[11] In support of US domestic insurers, non-US reinsurers provide a majority of the available reinsurance protection to fulfill the needs of the US insurance market. In 2018, offshore reinsurers assumed 65.7 percent of US ceded premiums in 2018.[12] Together, offshore reinsurers and alien-owned[13] US reinsurers assumed 88.9 percent of US ceded premiums during the same year.[14]Such access to alien reinsurance contributes to the global diversification of risk, provides claims burden relief to US reinsurers, and mitigates financial impacts of catastrophes.[15]

The purchase of reinsurance from reinsurers not domiciled or licensed in the US may expose US domestic insurers to additional credit risk to the extent that any reinsurer is unable to meet the obligation assumed in the reinsurance contract. It similarly presents significant challenges to US state insurance regulators charged with regulating insurer solvency.

Direct Regulation of Authorized Reinsurers

OIR directly regulates authorized reinsurers[16] domiciled and licensed in Florida as well as reinsurers licensed in Florida but domiciled in a foreign state.[17] When an insurer cedes business to a licensed reinsurer, the insurer is permitted under statutory accounting rules to recognize a reduction in its liabilities for the amount of ceded liabilities, without a regulatory requirement for the reinsurer to post collateral to secure the reinsurer's ultimate payment of the reinsured liabilities.[18] A reinsurer licensed in a state is subject to solvency and other regulations imposed by the state which are applicable to insurance companies generally.

[10] *See supra* Note 7.
[11] *Id*.
[12] Reinsurance Association of America, *Offshore Reinsurance in the US Market: 2018 Data*, https://www.reinsurance.org/RAA/Industry_Data_Center/Offshore_Report/Offshore_Report_2018_Data.html (last visited January 13, 2020).
[13] In the insurance context, "alien" means domiciled in a foreign country. "Alien" is distinguishable from "foreign," which means domiciled in a state other than the one in which the company is writing business.
[14] *Id*.
[15] International Association of Insurance Supervisors, *Reinsurance and Financial Stability* (July 2012), https://www.iaisweb.org/file/34046/reinsurance-and-financial-stability (last visited January 13, 2020).
[16] An "authorized" reinsurers is one that is licensed or accredited in a given state.
[17] Section 624.610(3)(a),(b), F.S.
[18] *Id*.

Indirect Regulation of Unauthorized Reinsurers

In the absence of direct supervisory authority, OIR indirectly regulates unauthorized reinsurers[19] by limiting the ceding insurer's credit for reinsurance unless the reinsurer posts collateral to secure the reinsurer's ultimate payment of the reinsured liabilities.[20]

The 2007 Legislature reduced the collateral requirements for insurers to receive credit for reinsurance commensurate with the financial strength of the reinsurer and the quality of the regulatory regime, and authorized OIR to enact rulemaking to implement corresponding regulatory changes.[21] In considering whether to allow credit for reinsurance, the reinsurer must hold surplus in excess of $250 million and have a secure financial strength rating (SFSR) from at least two statistical rating organizations deemed acceptable by the Commissioner of OIR (Commissioner).[22] The Commissioner must also consider:

- The domiciliary regulatory jurisdiction of the reinsurer;
- The structure and authority of the domiciliary regulator with regard to solvency regulation and the financial surveillance of the reinsurer;
- The substance of financial and operating standards for reinsurers in the domiciliary jurisdiction;
- The form and substance of financial reports required to be filed by the reinsurers in the domiciliary jurisdiction or other public financial statements filed in accordance with generally accepted accounting principles;
- The domiciliary regulator's willingness to cooperate with US regulators in general and OIR in particular;
- The history of performance by reinsurers in the domiciliary jurisdiction;
- Any documented evidence of substantial problems with the enforcement of valid US judgments in the domiciliary jurisdiction; and
- Any other matters deemed relevant by the Commissioner.[23]

The collateral required to allow 100 percent credit shall be no less than the percentage specified for the lowest rating as indicated in the SFSR below:[24]

Rating	Collateral Required	AM Best	S&P	Moody's	Fitch	Demotech
Secure – 1	0%	A++	AAA	Aaa	AAA	A"
Secure – 2	10%	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-	A'
Secure – 3	20%	A	A+, A	A1, A2	A+, A	A

[19] An "unauthorized" reinsurer fails to meet the definition of an authorized reinsurer. *See supra* Note 13. Furthermore, "unauthorized" is distinguishable from "non-US". A US reinsurer that does not meet the definition of "authorized" reinsurer is considered "unauthorized". However, non-US reinsurers cannot become accredited in a US state based on their own domestic license.

[20] Historically, in order to receive financial statement credit for unauthorized reinsurance, a US insurer must have been the beneficiary of security posted by the unauthorized reinsurer, providing collateral equal to 100 percent of the actuarially-estimated liabilities under the reinsurance contract.

[21] Chapter 2007-1, s. 15, L.O.F.

[22] Section 624.610(3)(e), F.S.

[23] Section 624.610(3)(e)(1)-(8), F.S.

[24] 69O-144.007(4), F.A.C.

Secure – 4	50%	A-	A-	A3	A-	n/a
Secure – 5	75%	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-	n/a
Vulnerable – 6	100%	B, B-, C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD	n/a

Revisions to NAIC Model Law 785 and Regulation 786

The 2019 revisions to the National Association of Insurance Commissioners (NAIC) Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) incorporate substantive provisions from the 2017 Bilateral Agreement between the United States of America and European Union on Prudential Measures Regarding and Reinsurance (Covered Agreement) reached between the US Department of the Treasury, US Trade Representative, and the European Union.

The Covered Agreement, in part, commits the US to phasing-out state-based reinsurance collateral requirements for EU reinsurers by 2022.[25] It further exempts EU reinsurers from current US domiciliary requirements for authorized reinsurer status by creating a new, broader classification of jurisdiction called "reciprocal jurisdiction."[26] Credit for Reinsurance Model Law (#785) defines a "reciprocal jurisdiction" as a jurisdiction that meets one of the following requirements:

- A non-US jurisdiction that is subject to an in-force covered agreement with the US, each within its legal authority, or, in the case of a covered agreement between the US and EU, is a member state of the EU;
- A US jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or
- A qualified jurisdiction, as determined by the Commissioner.[27]

Covered agreements are authorized under 31 U.S.C ss. 313 and 314. A covered agreement is a written bilateral or multilateral agreement regarding prudential measures with respect to the business of insurance or reinsurance that is entered into between the United States and one or more foreign governments, authorities, or regulators for the purpose of recognizing prudential measures with respect to insurance or reinsurance that achieve a level of protection for insurance or reinsurance consumers that is substantially equivalent to the level of protection achieved under state insurance or reinsurance regulation.[28]

[25] US Department of Treasury, Federal Insurance Office, *Statement of the United States on the Covered Agreement with the European Union* (September 22, 2017), https://home.treasury.gov/system/files/311/US_Covered_Agreement_Policy_Statement_Issued_September_2017_1.pdf (last visited January 13, 2020).
[26] *Id*.
[27] National Association of Insurance Commissioners, *Credit for Reinsurance Model Law-785*, (Summer 2019), https://www.naic.org/store/free/MDL-785.pdf (last visited January 13, 2020).
[28] 31 U.S.C. s. 313(r)(2).

NAIC Accreditation and Adoption of Model Laws

NAIC accreditation is a certification that legal, regulatory, and organizational oversight standards and practices are being fulfilled by a state insurance department to promote sound insurer financial solvency regulation. The accreditation program is also designed to allow for interstate cooperation and reduces regulatory redundancies.[29] For example, the OIR's examinations may be recognized by other member states, thereby avoiding the need to have a Florida domestic insurer examined by multiple states.[30]

Currently, all 50 states, the District of Columbia and Puerto Rico are accredited. Once accredited, a state is subject to a full accreditation review every five years, as well as interim reviews.[31] One major component of NAIC accreditation standards is the adequacy of solvency laws and regulations in each accredited state to protect consumers and guaranty funds, through the adoption of model laws.[32]

Effective January 1, 2019, NAIC included the 2011 revisions to the Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) as accreditation standards.[33] It subsequently included the 2019 revisions to Credit for Reinsurance Model Law (#785) and Credit for Reinsurance Model Regulation (#786) as accreditation standards to be effective October 1, 2022.[34]

III. Effect of Proposed Changes:

Section 1 amends s. 624.610, F.S., which provides the criteria under which an insurer is given credit for reinsurance. The bill provides insurers with credit for reinsurance if the reinsurer is domiciled in a "reciprocal jurisdiction" and meets the requirements of this section. It defines "reciprocal jurisdiction" as a jurisdiction that is:

- A non-US jurisdiction that is subject to an in-force covered agreement[35] with the US or, in the case of a covered agreement between the United States and the European Union,[36] an EU member state;
- A US jurisdiction that meets the NAIC's requirements for accreditation; or
- Any other qualified jurisdiction that meets the OIR's requirements as set forth in rule.

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[29] National Association of Insurance Commissioners, *Financial Regulation Standards and Accreditation Program* (December 2019), https://content.naic.org/sites/default/files/inline-files/FRSA%20Pamphlet%2012-2019_0.pdf (last visited January 13, 2020).
[30] *Id*.
[31] National Association of Insurance Commissioners, *State Legislative Brief: The NAIC Accreditation Program* (November 2019), https://www.naic.org/documents/cmte_legislative_liaison_brief_accreditation.pdf (last visited January 13, 2020).
[32] *See supra* Note 23.
[33] *Id*.
[34] National Association of Insurance Commissioners, *CIPR Topics: Reinsurance* (September 1, 2019), https://content.naic.org/cipr_topics/topic_reinsurance.htm (last visited January 13, 2020).
[35] The bill defines a "covered agreement" to mean an agreement entered into pursuant 31 U.S.C ss. 313 and 314 (The Dodd-Frank Wall Street Reform and Consumer Protection Act) which is effective or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.
[36] The United States entered into such an agreement on September 22, 2017, the Bilateral Agreement Between the United States of America and the European Union on Prudential Measures Regarding Insurance and Reinsurance.

A reinsurer domiciled in a reciprocal jurisdiction must maintain minimum capital and surplus amounts, and a minimum solvency or capital ratio as specified by financial services commission rule. The reinsurer's supervisory authority must annually confirm to OIR whether the reinsurer complies with these minimum requirements. In the event the reinsurer falls below these minimum requirements, or if regulatory action is taken against it for serious noncompliance with applicable law, the reinsurer must provide written notice to OIR.

The reinsurer must consent to the jurisdiction of Florida state courts and the designation of the Chief Financial Officer for purposes of lawful service of process in any action, suit, or proceeding brought by the insurer against the reinsurer. The reinsurer must consent to pay all final judgements declared enforceable in the jurisdiction where the judgment was obtained, and the reinsurance contract must contain a provision requiring the reinsurer to provide security equal to 100 percent of reinsurance liabilities in the event the reinsurer resists enforcement of a final judgment or a properly enforceable arbitration award.

The reinsurer must agree to provide security equal to 100 percent of reinsurance liabilities and notify the insurer if the reinsurer enters into receivership for conservation, rehabilitation, or liquidation purposes.

The reinsurer must pay claims promptly pursuant to OIR rule.

The reinsurer must provide documentation to the OIR required by commission rule and may provide to the OIR information on a voluntary basis.

OIR may revoke the reinsurer's eligibility for recognition if the reinsurer fails to meet one or more of the requirements of the subsection. In the event OIR revokes the reinsurer's eligibility, the insurer does not qualify for credit for reinsurance except to the extent the reinsurer has provided collateral to secure the reinsurance liabilities.

Many reinsurers domiciled in what the bill defines as "reciprocal jurisdictions" are currently required under Florida law to hold surplus in excess of $250 million and have a secure financial strength rating from at least two statistical rating agencies.[37] The bill will allow reinsurers in reciprocal jurisdictions to instead meet the requirements created by this bill. This will allow insurers in this state to receive credit for reinsurance obtained from reinsurers with a surplus of less than $250 million if the reinsurer domiciled in a reciprocal jurisdiction and otherwise meets the requirements established by the bill.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[37] See s. 624.610(3)(e), F.S.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

At line 194, the bill references "certain additional requirements" that would be requisite conditions for the Office of Insurance Regulation to determine whether a jurisdiction is a qualified jurisdiction, but neither lists such additional requirements nor specifies standards or guidelines for the Office of Insurance Regulation to promulgate rules.

At line 258, the bill references "certain documentation" the reinsurer or its successors must provide the Office of Insurance Regulation upon request by the Office of Insurance Regulation, but neither lists such documentation nor specifies standards or guidelines for the Office of Insurance Regulation to promulgate rules

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Allowing insurers to receive credit for reinsurance and eliminating additional collateral requirements for reinsurers if the reinsurer is domiciled in a "reciprocal jurisdiction" provides US domestic insurers with greater access to global reinsurance and improves diversifying of risk.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 624.610 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Broxson

1-00904A-20 20201376__

A bill to be entitled

An act relating to credit for reinsurance; amending s. 624.610, F.S.; adding conditions under which a ceding insurer must be allowed credit for reinsurance; defining the terms "reciprocal jurisdiction" and "covered agreement"; specifying requirements for assuming insurers and reinsurance agreements; requiring the Financial Services Commission to adopt certain rules; authorizing a ceding insurer or its representative that is subject to rehabilitation, liquidation, or conservation to seek a certain court order; specifying a limitation on credit taken by a ceding insurer; authorizing the Office of Insurance Regulation to revoke or suspend an assuming insurer's eligibility under certain conditions; providing construction; deleting an obsolete provision; conforming provisions to changes made by the act; making technical changes; providing an effective date.

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

Section 1. Present subsections (4) through (14) of section 624.610, Florida Statutes, are redesignated as subsections (5) through (15), respectively, a new subsection (4) is added to that section, and subsection (2), paragraphs (c) and (e) of subsection (3), present subsections (4) and (15), paragraph (a) of present subsection (5), and paragraph (b) of present subsection (11) are amended, to read:

624.610 Reinsurance.—

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(2) Credit for reinsurance must be allowed a ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (3)(a), paragraph (3)(b), ~~or~~ paragraph (3)(c), or subsection (4). Credit must be allowed under paragraph (3)(a) or paragraph (3)(b) only for cessions of those kinds or lines of business that the assuming insurer is licensed, authorized, or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed or authorized to transact insurance or reinsurance.

(3)

(c)1. Credit must be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund in a qualified United States financial institution, as defined in paragraph (6)(b) ~~(5)(b)~~, for the payment of the valid claims of its United States ceding insurers and their assigns and successors in interest. To enable the office to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the office information substantially the same as that required to be reported on the NAIC Annual Statement form by authorized insurers. The assuming insurer shall submit to examination of its books and records by the office and bear the expense of examination.

2.a. Credit for reinsurance must not be granted under this subsection unless the form of the trust and any amendments to the trust have been approved by:

(I) The insurance regulator of the state in which the trust is domiciled; or

(II) The insurance regulator of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

b. The form of the trust and any trust amendments must be filed with the insurance regulator of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims are valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the insurance regulator.

c. The trust remains in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year, the trustee of the trust shall report to the insurance regulator in writing the balance of the trust and list the trust's investments at the preceding year end, and shall certify that the trust will not expire prior to the following December 31.

3. The following requirements apply to the following categories of assuming insurer:

a. The trust fund for a single assuming insurer consists of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20 million. Not

less than 50 percent of the funds in the trust covering the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers and trusteed surplus shall consist of assets of a quality substantially similar to that required in part II of chapter 625. Clean, irrevocable, unconditional, and evergreen letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (6)(a) ~~(5)(a)~~, effective no later than December 31 of the year for which the filing is made and in the possession of the trust on or before the filing date of its annual statement, may be used to fund the remainder of the trust and trusteed surplus.

b.(I) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment, or renewal date on or after August 1, 1995, the trust consists of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group;

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of this section, the trust consists of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States; and

(C) In addition to these trusts, the group shall maintain in trust a trusteed surplus of which $100 million must be held

jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(II) The incorporated members of the group must not be engaged in any business other than underwriting of a member of the group, and are subject to the same level of regulation and solvency control by the group's domiciliary regulator as the unincorporated members.

(III) Within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the insurance regulator an annual certification by the group's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(e) If the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), paragraph (b), paragraph (c), or paragraph (d), the office ~~commissioner~~ may allow credit, but only if the assuming insurer holds surplus in excess of $250 million and has a secure financial strength rating from at least two statistical rating organizations deemed acceptable by the office ~~commissioner~~ as having experience and expertise in rating insurers doing business in Florida, including, but not limited to, Standard & Poor's, Moody's Investors Service, Fitch Ratings, A.M. Best Company, and Demotech. In determining whether credit should be allowed, the office ~~commissioner~~ shall consider the following:

1. The domiciliary regulatory jurisdiction of the assuming insurer.

2. The structure and authority of the domiciliary regulator

with regard to solvency regulation requirements and the financial surveillance of the reinsurer.

3. The substance of financial and operating standards for reinsurers in the domiciliary jurisdiction.

4. The form and substance of financial reports required to be filed by the reinsurers in the domiciliary jurisdiction or other public financial statements filed in accordance with generally accepted accounting principles.

5. The domiciliary regulator's willingness to cooperate with United States regulators in general and the office in particular.

6. The history of performance by reinsurers in the domiciliary jurisdiction.

7. Any documented evidence of substantial problems with the enforcement of valid United States judgments in the domiciliary jurisdiction.

8. Any other matters deemed relevant by the office ~~commissioner~~. The office ~~commissioner~~ shall give appropriate consideration to insurer group ratings that may have been issued. The office ~~commissioner~~ may, in lieu of granting full credit under this subsection, reduce the amount required to be held in trust under paragraph (c).

(4) Credit must be allowed when the reinsurance is ceded to an assuming insurer meeting the requirements of this subsection.

(a) The assuming insurer must be licensed in, and have its head office in or be domiciled in, as applicable, a reciprocal jurisdiction. As used in this subsection, the term "reciprocal jurisdiction" means a jurisdiction that is any of the following:

1. A non-United States jurisdiction that is subject to an

in-force covered agreement with the United States, each within its legal authority; or, in the case of a covered agreement between the United States and the European Union, a jurisdiction that is a member state of the European Union. As used in this paragraph, the term "covered agreement" means an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. ss. 313 and 314, which is currently in effect or in a period of provisional application and which addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

2. A United States jurisdiction that meets the requirements for accreditation under the Financial Regulation Standards and Accreditation Program of the National Association of Insurance Commissioners.

3. A qualified jurisdiction, as determined by the office, which is not otherwise described in subparagraph 1. or subparagraph 2. and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by commission rule.

(b) The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount specified by commission rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain on an ongoing basis minimum capital and surplus

equivalents (net of liabilities) calculated according to the methodology applicable in its domiciliary jurisdiction, and a central fund containing a balance in amounts specified by commission rule.

(c) The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as specified by commission rule. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain on an ongoing basis a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer is licensed and has its head office or where it is domiciled, as applicable.

(d) The assuming insurer must agree and provide adequate assurance to the office, in a form specified by the commission, of all of the following:

1. Prompt written notice and explanation to the office if the assuming insurer falls below the minimum requirements set forth in paragraph (b) or paragraph (c), or if any regulatory action is taken against it for serious noncompliance with applicable law.

2. The assuming insurer's written consent to the jurisdiction of the courts of this state and designation of the Chief Financial Officer, pursuant to s. 48.151, or of a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit, or proceeding instituted by or on behalf of the ceding company. This subparagraph does not limit or alter the capacity of parties to a reinsurance agreement to agree to an alternative dispute resolution mechanism, except to the extent that such

agreements are unenforceable under applicable insolvency or delinquency laws.

3. The assuming insurer's written consent to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor which have been declared enforceable in the jurisdiction where the judgment was obtained.

4. Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100 percent of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement, if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or of a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate.

5. The assuming insurer's confirmation that it is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers, and must agree to notify the ceding insurer and the office and to provide security in an amount equal to 100 percent of the assuming insurer's liabilities to the ceding insurer if the assuming insurer enters into such a solvent scheme of arrangement. Such security must be consistent with subsection (3) and this subsection.

(e) If requested by the office, the assuming insurer or its legal successor must provide on behalf of itself and any legal predecessors certain documentation to the office pursuant to criteria set forth by commission rule.

(f) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements pursuant to

criteria set forth by commission rule.

(g) The assuming insurer's supervisory authority must confirm to the office on an annual basis, on a form adopted by the commission, that, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, the assuming insurer complied with the requirements of paragraphs (b) and (c).

(h) This subsection does not preclude an assuming insurer from providing the office with information on a voluntary basis.

(i) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer or its representative may seek and, if determined appropriate by the court in which the proceedings are pending, obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(j) This subsection does not limit or alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in the reinsurance agreement, except as expressly prohibited by this section or other applicable law or rule of the commission.

(k)1. Credit may be taken under this subsection only for reinsurance agreements entered into, amended, or renewed on or after the date on which the assuming insurer has satisfied the requirements to assume reinsurance under this subsection, and only with respect to losses incurred and reserves reported on or after the later of the date on which the assuming insurer has met all eligibility requirements pursuant to this subsection or the effective date of the new reinsurance agreement, amendment, or renewal.

2. This paragraph does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this subsection, if the reinsurance qualifies for credit under any other applicable provision of this section.

3. This subsection does not authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement, except as permitted by the terms of the agreement.

4. This subsection does not limit or alter the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(l) If the office determines that an assuming insurer no longer meets one or more of the requirements under this subsection, the office may revoke or suspend the eligibility of the assuming insurer for recognition under this subsection.

1. During the suspension of an assuming insurer's eligibility, a reinsurance agreement issued, amended, or renewed after the effective date of the suspension does not qualify for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with this subsection.

2. If an assuming insurer's eligibility is revoked, a credit for reinsurance may not be granted after the effective date of the revocation with respect to any reinsurance agreement entered into by the assuming insurer, including a reinsurance agreement entered into before the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the office and

consistent with this subsection.

(5)~~(4)~~ An asset allowed or a deduction from liability taken for the reinsurance ceded by an insurer to an assuming insurer not meeting the requirements of subsections (2), ~~and~~ (3), and (4) is allowed in an amount not exceeding the liabilities carried by the ceding insurer. The deduction must be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (6)(b) ~~(5)(b)~~. This security may be in the form of:

(a) Cash in United States dollars;

(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as admitted assets pursuant to part II of chapter 625;

(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (6)(a) ~~(5)(a)~~, effective no later than December 31 of the year for which the filing is made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement; or

(d) Any other form of security acceptable to the office.

(6)(a)~~(5)(a)~~ For purposes of paragraph (5)(c) ~~(4)(c)~~ regarding letters of credit, a "qualified United States

financial institution" means an institution that:

1. Is organized or, in the case of a United States office of a foreign banking organization, is licensed under the laws of the United States or any state thereof;

2. Is regulated, supervised, and examined by United States or state authorities having regulatory authority over banks and trust companies; and

3. Has been determined by either the office or the Securities Valuation Office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the office.

(12) ~~(11)~~

(b) The summary statement must be signed and attested to by either the chief executive officer or the chief financial officer of the reporting insurer. In addition to the summary statement, the office may require the filing of any supporting information relating to the ceding of such risks as it deems necessary. If the summary statement prepared by the ceding insurer discloses that the net effect of a reinsurance treaty or treaties (or series of treaties with one or more affiliated reinsurers entered into for the purpose of avoiding the following threshold amount) at any time results in an increase of more than 25 percent to the insurer's surplus as to policyholders, then the insurer shall certify in writing to the office that the relevant reinsurance treaty or treaties comply with the accounting requirements contained in any rule adopted by the commission under subsection (15) ~~(14)~~. If such

certificate is filed after the summary statement of such reinsurance treaty or treaties, the insurer shall refile the summary statement with the certificate. In any event, the certificate must state that a copy of the certificate was sent to the reinsurer under the reinsurance treaty.

~~(15) Any reinsurer approved pursuant to s. 624.610(3)(a)2., as such provision existed prior to July 1, 2000, which fails to obtain accreditation pursuant to this section prior to December 30, 2003, shall have its approval terminated by operation of law on that date.~~

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

11/21/20
Meeting Date

1376
Bill Number (if applicable)

Topic Credit For Reinsurance

Amendment Barcode (if applicable)

Name George Feijoo ("Fay-Jew")

Job Title Consultant

Address 108 S. Monroe St.
Street

Phone 305 720 7099

Tallahassee FL 32301
City *State* *Zip*

Email gfeijoo@flapartners.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Insurance Council

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

This form is part of the public record for this meeting

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/21/20
Meeting Date

SB 1376
Bill Number (if applicable)

Topic Credit for Reinsurance

Amendment Barcode (if applicable)

Name Susanne K. Murphy

Job Title Deputy Insurance Commissioner

Address 200 E. Gaines Street
Street

Phone (850) 413-5083

Tallahassee FL 32399
City *State* *Zip*

Email susanne.murphy@floir.com

Speaking: ☑ For ☐ Against ☑ Information

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

Representing Office of Insurance Regulation

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

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 1404
INTRODUCER:	Banking and Insurance Committee and Senator Perry
SUBJECT:	Department of Financial Services
DATE:	January 21, 2020
REVISED:	

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

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1404 is the 2020 legislative Package for the Department of Financial Services (DFS). This bill amends sections of Florida Statutes governing the following DFS Divisions: Investigative and Forensic Services; Public Assistance Fraud; Funeral, Cemetery, and Consumer Services; and State Fire Marshal. The bill:

- Designates the Division of Public Assistance Fraud a criminal justice agency.
- Amends the composition requirements of the Board of Funeral, Cemetery, and Consumer Services; clarifies member requirements, amends the definition of "quorum" to enable ease of business; removes term staggering requirements; and clarifies rulemaking responsibilities.
- Clarifies and provides grounds for disqualification of death care licensure applicants based on criminal history.
- Increases criminal penalties associated with unlicensed funeral activity.
- Updates the definition of "two-component explosive" to reflect changes in the marketplace.
- Allows contractors to begin repairs on a previously permitted fire alarm prior to receiving a permit to do so, yet maintains that such repair will not be compliant until permitted and approved.
- Prohibits influencing a firesafety inspector to violate applicable law through threats, coercion, trickery, or compensation, and prohibits a firesafety inspector from knowingly and willingly accepting such an attempt.
- Allows fire service providers to hire volunteer firefighters, and allow them to continue to function in volunteer firefighter capacity for the first year of employment while they obtain career firefighter certifications.

- Expands the applicability of criminal penalties for impersonation to investigators and personnel of DFS.

The effective date is July 1, 2020.

II. Present Situation:

Division of Public Assistance Fraud

The Division of Public Assistance Fraud (PAF) is responsible for enforcing state laws regarding program eligibility and proper use of public assistance benefits. PAF is responsible for investigating allegations of fraud related to the Cash Assistance/Temporary Assistance for Needy Families (TANF) program, the Supplemental Nutritional Assistance Program (SNAP); Medicaid recipients; disaster assistance/emergency benefits; the School Readiness and Voluntary Pre-Kindergarten programs; and Social Security Disability benefits.[1]

PAF has operated as a criminal justice agency since its inception in 1972, however, PAF is currently undefined in regard to its status as a criminal justice agency.[2] Under Florida law, a criminal justice agency is defined, in part, as any governmental agency or subunit thereof that performs the administration of criminal justice pursuant to a statute or rule of court and that allocates a substantial part of its annual budget to the administration of criminal justice.[3]

Funeral, Cemetery, and Consumer Services

Composition and Business of Board of Funeral, Cemetery, and Consumer Services

Section 20.121(4), F.S., creates the Board of Funeral, Cemetery, and Consumer Services (Board) within the Division of Funeral, Cemetery, and Consumer Services of the Department of Financial Services. The board acts as the licensing authority for the purposes of certain matters related to examinations and other substantive requirements for licensure within the death care industry under ch. 497, F.S., including facility requirements.[4]

Currently, the board must have 10 members; one member must be the State Health Officer, or their designee, and the remaining 9 members must be nominated by the Chief Financial Officer

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[1] Division of Public Assistance, https://myfloridacfo.com/Division/PAF/ (last visited January 16, 2020).
[2] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).
[3] Section 943.045(11)(e), F.S. *See also*: s. 943.045(2), F.S.; the term "administration of criminal justice" means "performing functions of detection, apprehension, detention, pretrial release, posttrial release, prosecution, adjudication, correctional supervision, or rehabilitation of accused persons or criminal offenders by governmental agencies. The administration of criminal justice includes criminal identification activities and the collection, processing, storage, and dissemination of criminal justice information by governmental agencies."
[4] *See* s. 497.103(1)(a)-(cc), F.S. Licenses available to natural persons include: embalmer apprentice and intern; funeral directors and intern; funeral director and embalmer, direct disposer, monument establishment sales agent, and preneed sales agent. s. 497.141(12)(a), F.S. Licenses available to natural persons, corporations, limited liability companies, and partnerships include: funeral establishment, centralized embalming facility, refrigeration facility, direct disposal establishment, monument establishment, cinerator facility, removal service, preneed sales business under s. 497.453, F.S., and cemetery. s. 497.141(12)(b)-(c), F.S.

(CFO), appointed by the Governor, and confirmed by the Senate.[5] The composition of the board must be as follows:

- The State Health Officer.
- Two funeral directors who are:
  - licensed under part III of ch. 497, F.S., as funeral directors, and
  - associated with a funeral establishment.
- One funeral director who is:
  - licensed under part III of ch. 497, F.S.,
  - associated with a funeral establishment licensed under part III of ch. 497, F.S., that has a valid preneed license issued pursuant to ch. 497, F.S., and
  - operates a incinerator facility that is approved under ch. 403, F.S., and licensed under part IV of ch. 497, F.S.
- Two persons whose primary occupation is associated with a licensed cemetery.
- Three consumers who:
  - are residents of Florida,
  - have never been licensed funeral directors or embalmers,
  - are not connected with a cemetery or licensed cemetery company, and
  - are not connected to the death care industry or the practice of embalming, funeral directing, or direct disposition,
  - at least one of which is at least 60 years of age,
  - at least one of which is a licensed certified public accountant.
- One principal of a monument establishment licensed under ch. 497, F.S., as a monument builder.

Members must not be principals or employees of the same company or partnership, or group of companies or partnerships under common control.[6] DFS reports that the CFO often does not receive a sufficient amount of applications to fill member positions.[7] For example, the position that must be filled by a certified public accountant has remained open since 2017.[8]

Board members are appointed for 4 year terms, except for the State Health Officer, who serves as long as they hold office.[9] The CFO is authorized to stagger the terms of members after the terms of the initial members expire.[10] The terms have already been staggered at the initiation of the board.[11]

[5] Section 497.101(1), F.S.
[6] Section 497.101(2), F.S.
[7] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).
[8] *Id.*
[9] Section 497.101(3), F.S.
[10] *Id.*
[11] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).

A quorum is necessary to conduct the business of the board. A quorum consists of six members of the board.[12] DFS indicates that it can be difficult to obtain this number due to board vacancies, absenteeism, and necessary recusal.[13]

DFS is required to adopt rules regarding application forms and procedures for appointment to the board.[14]

Disqualification of Licensure Applicants

Section 497.142(10), F.S., requires all licensure and licensure renewal applicants to disclose criminal history. The following crimes must be disclosed:

- Any felony or misdemeanor, no matter when committed, that was directly or indirectly related to or involving any aspect of the practice or business of funeral directing, embalming, direct disposition, cremation, funeral or cemetery preneed sales, funeral establishment operations, cemetery operations, or cemetery monument or marker sales or installation;
- Any other felony committed within the 20 years preceding the application; and
- Any other misdemeanor committed within the 5 years preceding the application.

Unlicensed Practice

Chapter 497, F.S., requires individuals to maintain a license for specified death care industry practices. DFS is authorized to issue administrative complaints against entities believed to be in violation of licensure requirements.[15] Section 497.159, F.S., provides for criminal penalties; unlicensed activity is a second degree misdemeanor, punishable as provided in s. 775.082, F.S., or s. 775.083, F.S.[16]

Explosives

Chapter 552, F.S., sets forth the requirements to lawfully engage in the business of a manufacturer-distributor, or to acquire, sell, possess, store, or engage in the use of explosives in this state. The chapter's current definition of a two-component explosive requires the use of a "No. 6 blasting cap" for detonation.[17] No. 6 blasting caps went out of production several years ago and current blasting caps no longer use the same rating system.[18]

Fire Alarm Permits

Contractors are required to file a Uniform Fire Alarm Permit Application with a local law enforcement agency, and must receive the permit before installing, replacing, or repairing an

[12] Section 497.101(6), F.S.
[13] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).
[14] *Id.*, s. 497.103(2)(c), F.S.
[15] Section 497.157(2), F.S.
[16] Section 497.159(6), F.S.
[17] Section 552.081(13), F.S.
[18] Department of Financial Services, *Legislative Bill Analysis of SB 1404, January 14, 2020* (on file with Senate Banking and Insurance Committee).

existing fire alarm that was previously permitted by the local enforcement agency, if the local enforcement agency requires a permit for the repair.[19]

Firesafety Inspectors

Section 633.216, F.S., requires each county, municipality, and special district that has firesafety enforcement responsibilities to employ or contract with a firesafety inspector. Subject to certain exceptions[20], the firesafety inspector is responsible for conducting all firesafety inspections required by law.[21] These firesafety inspections include the inspection of buildings and facilities, on a recurring or regular basis, on behalf of the state or any county, municipality, or special district with fire safety responsibilities.[22] The Florida Fire Prevention Code[23] governs design, construction, erection, alteration, modification, repair, and demolition of public and private buildings, structures, and facilities and the enforcement of such firesafety laws and rules. These local enforcing authorities may adopt more stringent firesafety standards, subject to certain requirements in s. 633.208, F.S., but may not enact firesafety ordinances which conflict with ch. 633, F.S., or any other state law.[24]

The Chief Financial Officer is designated as "State Fire Marshal."[25] In any county, municipality, or special district that does not employ or appoint a firesafety inspector, the State Fire Marshal assumes the duties of the local county, municipality, or independent special fire control district with respect to firesafety inspections of educational property.[26]

A person who violates any provision of ch. 633, F.S., Fire Prevention and Control, any order or rules of the State Fire Marshal, or any order to cease and desist or to correct conditions constitutes a misdemeanor of the second degree.[27]

It is illegal to impersonate the State Fire Marshal or firesafety inspector; a person who impersonates either official commits a felony of the third degree, and if the impersonation occurs during the commission of a separate felony, a person commits a felony of the first degree.[28] Section 468.629, F.S., makes it illegal for a person to influence a building code enforcement official by coercion or compensation.[29] Any person who commits such acts commits a misdemeanor of the first degree, and, if the person was previously convicted of such act, a felony of the third degree.[30]

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[19] Section 553.7921(1)(b), F.S.
[20] For example, this requirement does not apply to farm outbuildings or licensed plumbing contractor installed standpipe systems and certain connected items. S. 633.226, F.S.
[21] Section 633.216(1), F.S.
[22] Section 633.102(12), F.S.
[23] Chapter 69A-60, F.A.C. The Florida Fire Prevention Code is adopted by the State Fire Marshal, and contains and incorporates by reference all firesafety laws and rules. S. 633.202(1), F.S.
[24] *See* Rule 69A-60.002, F.A.C.; s. 633.214(4), F.S.
[25] Section 633.104(1), F.S.
[26] Section 633.104(7), F.S.
[27] Section 633.124(1), F.S.
[28] Section 633.122, F.S.
[29] Section 468.629(1)(f) and (g), F.S.
[30] Section 468.629(2), F.S.

Volunteer Firefighter Employment

The National Fire Prevention Association estimates that there were approximately 1,056,200 local firefighters in the United States as of 2017.[31] Of the total number of firefighters, 35 percent were career firefighters, and 65 percent were volunteer firefighters.[32] Florida has 528 fire departments.[33] More than 315 Florida fire departments utilize volunteers to sustain operations.[34] Approximately 12 million Florida residents depend on volunteer firefighters to protect their communities.[35] The Firefighter Assistance Grant Program, created in 2016 to improve the emergency response capability of fire departments reliant on volunteer firefighters, provides grant money to such fire departments to provide volunteer firefighter training and procure equipment. In 2018, 29 fire departments were awarded such grants.[36]

Florida fire service providers are currently prohibited from employing an individual to extinguish fires or to supervise those who do unless the individual holds a current and valid Firefighter Certificate of Compliance.[37] Thus, fire service providers are currently prohibited from employing volunteer firefighters, who hold a Volunteer Firefighter Certificate of Completion.[38] Volunteer firefighters can enter immediately dangerous to life and health (IDLH) environments. However, if employed by the same department prior to achieving a Firefighter Certificate of Compliance they would not be allowed to enter the IDLH environments they were authorized to enter the day before beginning career employment.[39]

False Personation

Pursuant to s. 843.08, F.S., any person who falsely assumes or pretends to be an officer of a specified type commits a felony of the third degree, a felony of the second degree when committed with another felony, and a felony in the first degree if the felony is the cause of death or personal injury of another individual.[40] A person who impersonates an officer of the DFS is subject to these criminal penalties.[41] However, there is no criminal penalty for impersonating an

[31] National Fire Prevention Association, U.S. Fire Department Profile, https://www.nfpa.org/News-and-Research/Data-research-and-tools/Emergency-Responders/US-fire-department-profile (Last visited January 16, 2020).
[32] *Id*.
[33] National Fire Prevention Association, *Number of U.S. Fire Departments by State*, https://www.nfpa.org/-/media/Files/News-and-Research/Fire-statistics-and-reports/Emergency-responders/osNumberOfFireDeptInUS.ashx?la=en (Last visited January 16, 2020).
[34] Division of State Fire Marshal, *Florida Volunteer Firefighter Information*, https://myfloridacfo.com/Division/SFM/VOLFF/default.htm (Last visited January 16, 2020).
[35] *Id*.
[36] Division of State Fire Marshal, *FY2018 Florida Firefighter Assistance Grant Award Outcomes*, https://myfloridacfo.com/Division/SFM/VOLFF/FY2018_GrantOutcomes.pdf (Last visited January 16, 2020).
[37] Section 633.416(1)(a), F.S.
[38] Section 633.408, F.S.
[39] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).
[40] Section 843.08, F.S., contains a list specifying which types of officers it is unlawful to impersonate. This list includes, but is not limited to, firefighters, sheriffs, officers of agencies, and school guardians.
[41] Section 843.08, F.S.

investigator or personnel of DFS. DFS employs personnel who are not officers but have access to active criminal cases and conduct criminal investigations.[42]

III. Effect of Proposed Changes:

Division of Public Assistance Fraud (Sections 1 and 9)

Section 1 amends s. 20.121(2)(f), F.S., to designate the Division of Public Assistance Fraud as a criminal justice agency for the purposes of ss. 943.045-943.08, F.S. The designation allows the division to continue having access to criminal justice information contained in FCIC and NCIC systems of criminal records when conducting criminal investigations and other law enforcement support functions.[43]

Section 10 amends s. 943.045, F.S., to include the Division of Public Assistance Fraud in the definition of "criminal justice agency."

Funeral, Cemetery, and Consumer Services

Composition and Business of Board of Funeral, Cemetery, and Consumer Services

Section 2 amends s. 497.101, F.S., to reduce the minimum number of nominations the CFO must make for nine board member positions from three nominations to one. The bill also reduces from three to two the number of positions on the board that must be filled by consumers who are residents of Florida, have never been licensed funeral directors or embalmers, are not connected with a cemetery or licensed cemetery company, nor connected to the death care industry or the practice of embalming, funeral directing, or direct disposition. The board must also now have a consumer member who is a resident, a licensed certified public accountant, who has never been licensed as a funeral director or embalmer, is not a principal or employee of any ch. 497, F.S., licensee, and does not otherwise have control (as defined in s. 497.005, F.S.) over any ch. 497, F.S., licensee. This change requires the appointment of a licensed CPA who has some knowledge of and association with, but not a controlling interest in, licensees in the death care industry.

The definition of a "quorum" for the purposes of conducting board business is amended to constitute a simple majority of eligible members instead of six members.

The section eliminates unnecessary statutory provisions regarding the staggered terms of Board members, which have already been established. The statutory change will also eliminate DFS rulemaking responsibilities concerning the application process, which DFS asserts is unnecessary, as the Governor makes the appointments.[44]

[42] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).
[43] *Id.*
[44] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).

Disqualification of Licensure Applicants

Section 3 of the bill creates s. 497.1411, F.S., to provide and clarify grounds for disqualification of licensure applicants based on criminal history. Subsection (1) provides definitions of "applicant," "felony of the first degree" and "capital felony," and "financial services business." Subsection (2) provides an enumerated list of crimes for which, if an applicant is found guilty of or pleads nolo contendere to, regardless of adjudication, are a permanent bar from licensure under ch. 497, F.S. These crimes are a first degree felony, a capital felony, a felony money laundering offense, or a felony embezzlement.

Subsection (3) provides the following disqualifying periods for other specified crimes:

- A 10-year disqualifying period for all felonies involving moral turpitude not subject to a permanent bar on licensure.
- A 5-year disqualifying period for all other felonies and for all misdemeanors directly related to the financial services business, defined as any financial activity regulated by DFS, the Office of Insurance Regulation, or the Office of Financial Regulation.

These specifications are intended to provide clarity beyond the current statutory scheme, which provides no guidelines to determine whether a specific crime is considered "directly or indirectly related to or involving any aspect of the practice or business" of death care industry functions. DFS suggests that the lack of clarity and guidance in current statute has led to inconsistencies in recommendations and Board rulings on applications.[45]

Subsection (4) requires DFS to adopt rules to administer the section. The rules must provide for additional disqualifying periods due to the commitment of multiple crimes and may include other factors reasonably related to the applicant's criminal history. The rules must also provide mitigating and aggravating factors, except that mitigation may not result in a disqualification period of less than 5 years.

Subsection (5) specifies that a disqualifying period begins upon an applicant's final release from supervision or upon completion of the applicant's criminal sentence. The subsection further prohibits DFS from issuing a license unless all related fines, court costs and fees, and court-ordered restitutions have been paid. Subsection (6) places the burden of proof for rehabilitation on the applicant.

Subsection (7) allows, but does not require, DFS to award a license, despite a conviction, upon a grant of a pardon or restoration of civil rights. Subsection (8) authorizes the board to grant an exemption from a criminal record related disqualification, and provides standards for mitigating factors. Chapter 120, F.S., administrative remedies are available to applicants for whom the board has granted or denied an exemption.

Unlicensed Practice

Section 4 of the bill amends s. 497.157, F.S., to increase penalties for unlicensed activity from a misdemeanor to a felony of the third degree, and expands unlicensed activity to include acting,

[45] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).

advertising, or otherwise holding oneself out to be a funeral director, embalmer, direct disposer, or preneed sales agent, unless currently licensed as such, or, in the case of a preneed sales agent, otherwise appointed by a licensee.

Explosives

Section 5 updates the definition of "two-component explosives" in s. 552.081, F.S., by removing the requirement of a "No. 6 cap," which is no longer manufactured.

Fire Alarm Permits

Section 6 amends s. 553.7921, F.S., to authorize contractors to begin repairs on existing, permitted fire alarms upon filing a Uniform Fire Alarm Permit Application, but prior to receiving the permit for the repair. Fire alarms repaired under such circumstances are not considered compliant until the permit is issued and the local law enforcement agency approves the repair.

Influencing a Firesafety Inspector

Section 7 creates s. 633.217, F.S., to prohibit influencing or attempting to influence a firesafety inspector by threatening, coercing, tricking, or offering compensation for the purpose of inducing the firesafety inspector to violate any provision of the Florida Fire Prevention Code, any rule adopted by the State Fire Marshal, or any provision of ch. 633, F.S. Subsection (2) prohibits a firesafety inspector from knowingly and willingly accepting an attempt by a person to influence them into violating any provision of the Florida Fire Prevention Code, any rule adopted by the State Fire Marshal, or any provision of ch. 633, F.S. As s. 633.124(1), F.S., provides that any person who violates any provision of ch. 633, F.S., commits a misdemeanor of the second degree, violations of s. 633.217, F.S., relating to influencing a firesafety inspector carry the criminal penalty of a misdemeanor of the second degree, punishable as provided in s. 775.082, F.S., or s. 775.083, F.S.

Volunteer Firefighter Employment

Section 8 amends s. 633.416, F.S., to authorize fire service providers to employ volunteer firefighters, and allow them to act in volunteer firefighter capacity for up to 1 year under the direct supervision of an individual holding a valid firefighter certificate of compliance, while they obtain career firefighter certifications. This will increase the availability of firefighters capable of entering immediately dangerous to life and health (IDLH) environments and protecting their communities. The DFS anticipates that this change will improve rural and small agency recruitment and retention efforts by facilitating the hiring of local candidates who are more inclined to remain in the area instead of hiring candidates.[46]

[46] Department of Financial Services, *Legislative Bill Analysis of SB 1404*, January 14, 2020 (on file with Senate Banking and Insurance Committee).

False Personation

Section 9 of the bill amends s. 843.08, F.S., to expand the applicability of criminal penalties associated with false personation to include false impersonation of DFS investigators and personnel.

Section 11 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 20.121, 497.101, 497.157, 552.081, 553.7921, 633.416, 843.08 and 943.045.

This bill creates section 497.1411 of the Florida Statutes.

IX. Additional Information:

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

CS by Banking and Insurance on January 21, 2020:
Creates s. 633.217, F.S., prohibiting the act of threatening, coercing, tricking, or attempting to threaten, coerce, or trick, or bribe a firesafety inspector for the purpose of influencing or inducing the firesafety officer to violate any provision of the Florida Fire Prevention Code, any rule adopted by the State Fire Marshal, or any other provision of ch. 633, F.S., which governs Fire Prevention and Control.

B. Amendments:

None.

830734

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
01/21/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 325 and 326
insert:

Section 7. Paragraphs (d), (g), and (h) of subsection (4) of section 633.304, Florida Statutes, are amended to read:

633.304 Fire suppression equipment; license to install or maintain.—

(4)

(d) A license of any class may not be issued or renewed by

the division and a license of any class does not remain operative unless:

1. The applicant has submitted to the State Fire Marshal evidence of registration as a Florida corporation or evidence of compliance with s. 865.09.

2. The State Fire Marshal or his or her designee has by inspection determined that the applicant possesses the equipment required for the class of license sought. The State Fire Marshal shall give an applicant a reasonable opportunity to correct any deficiencies discovered by inspection. To obtain such inspection, an applicant with facilities located outside this state must:

a. Provide a notarized statement from a professional engineer licensed by the applicant’s state of domicile certifying that the applicant possesses the equipment required for the class of license sought and that all such equipment is operable; or

b. Allow the State Fire Marshal or her or his designee to inspect the facility. All costs associated with the State Fire Marshal’s inspection must be paid by the applicant. The State Fire Marshal, in accordance with s. 120.54, may adopt rules to establish standards for the calculation and establishment of the amount of costs associated with any inspection conducted by the State Fire Marshal under this section. Such rules must include procedures for invoicing and receiving funds in advance of the inspection.

3. The applicant has submitted to the State Fire Marshal proof of insurance providing coverage for comprehensive general liability for bodily injury and property damage, products

liability, completed operations, and contractual liability. The State Fire Marshal shall adopt rules providing for the amounts of such coverage, but such amounts may not be less than $300,000 for Class A or Class D licenses, $200,000 for Class B licenses, and $100,000 for Class C licenses; and the total coverage for any class of license held in conjunction with a Class D license may not be less than $300,000. The State Fire Marshal may, at any time after the issuance of a license or its renewal, require upon demand, and in no event more than 30 days after notice of such demand, the licensee to provide proof of insurance, on the insurer's form, containing confirmation of insurance coverage as required by this chapter. Failure, for any length of time, to provide proof of insurance coverage as required must result in the immediate suspension of the license until proof of proper insurance is provided to the State Fire Marshal. An insurer that provides such coverage shall notify the State Fire Marshal of any change in coverage or of any termination, cancellation, or nonrenewal of any coverage.

4. The applicant applies to the State Fire Marshal, provides proof of experience, and successfully completes a prescribed training course that includes both written and practical training offered at ~~by~~ the State Fire College and ~~or an equivalent course~~ approved by the State Fire Marshal as applicable to the class of license being sought. This subparagraph does not apply to any holder of or applicant for a permit under paragraph (g) or to a business organization or a governmental entity seeking initial licensure or renewal of an existing license solely for the purpose of inspecting, servicing, repairing, marking, recharging, and maintaining fire

extinguishers used and located on the premises of and owned by such organization or entity.

5. The applicant has a current retestor identification number that is appropriate for the license for which the applicant is applying and that is listed with the United States Department of Transportation.

6. The applicant has passed, with a grade of at least 70 percent, a written examination testing his or her knowledge of the rules and statutes governing the activities authorized by the license and demonstrating his or her knowledge and ability to perform those tasks in a competent, lawful, and safe manner. Such examination must be developed and administered by the State Fire Marshal, or his or her designee in accordance with policies and procedures of the State Fire Marshal. An applicant shall pay a nonrefundable examination fee of $50 for each examination or reexamination scheduled. A reexamination may not be scheduled sooner than 30 days after any administration of an examination to an applicant. An applicant may not be permitted to take an examination for any level of license more than a total of four times during 1 year, regardless of the number of applications submitted. As a prerequisite to licensure of the applicant, he or she:

a. Must be at least 18 years of age.

b. Must have 4 years of proven experience as a fire equipment permittee at a level equal to or greater than the level of license applied for or have a combination of education and experience determined to be equivalent thereto by the State Fire Marshal. Having held a permit at the appropriate level for the required period constitutes the required experience.


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c. Must not have been convicted of a felony or a crime punishable by imprisonment of 1 year or more under the law of the United States or of any state thereof or under the law of any other country. "Convicted" means a finding of guilt or the acceptance of a plea of guilty or nolo contendere in any federal or state court or a court in any other country, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of the case. If an applicant has been convicted of any such felony, the applicant is excluded from licensure for a period of 4 years after expiration of sentence or final release by the Florida Commission on Offender Review unless the applicant, before the expiration of the 4-year period, has received a full pardon or has had her or his civil rights restored.

This subparagraph does not apply to any holder of or applicant for a permit under paragraph (g) or to a business organization or a governmental entity seeking initial licensure or renewal of an existing license solely for the purpose of inspecting, servicing, repairing, marking, recharging, hydrotesting, and maintaining fire extinguishers used and located on the premises of and owned by such organization or entity.

(g) A permit of any class may not be issued or renewed to a person by the division, and a permit of any class does not remain operative, unless the person has:

1. Submitted a nonrefundable examination fee in the amount of $50.

2. Successfully completed a training course that includes both written and practical training offered at ~~by~~ the State Fire

College and ~~or an equivalent course~~ approved by the State Fire Marshal as applicable to the class of license being sought.

3. Passed, with a grade of at least 70 percent, a written examination testing his or her knowledge of the rules and statutes governing the activities authorized by the permit and demonstrating his or her knowledge and ability to perform those tasks in a competent, lawful, and safe manner. Such examination must be developed and administered by the State Fire Marshal in accordance with the policies and procedures of the State Fire Marshal. An examination fee must be paid for each examination scheduled. A reexamination may not be scheduled sooner than 30 days after any administration of an examination to an applicant. An applicant may not be permitted to take an examination for any level of permit more than four times during 1 year, regardless of the number of applications submitted. As a prerequisite to taking the permit examination, the applicant must be at least 16 years of age.

(h) An applicant for a license or permit under this section who fails the examination may take it three more times during the 1-year period after he or she originally filed an application for the examination. If the applicant fails the examination within 1 year after the application date and he or she seeks to retake the examination, he or she must file a new application, pay the application and examination fees, and successfully complete a prescribed training course that includes both written and practical training offered at ~~by~~ the State Fire College and ~~or an equivalent course~~ approved by the State Fire Marshal as applicable to the class of license being sought. The applicant may not submit a new application within 6 months after

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the date of his or her fourth reexamination. An applicant who passes the examination but does not meet the remaining qualifications prescribed by law and rule within 1 year after the application date must file a new application, pay the application and examination fee, successfully complete a prescribed training course that includes both written and practical training offered at ~~approved by~~ the State Fire College and ~~or an equivalent course~~ approved by the State Fire Marshal as applicable to the class of license being sought, and pass the written examination.

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

And the title is amended as follows:

Delete line 35

and insert:

construction; amending s. 633.304, F.S.; specifying that training courses offered by the State Fire College must include a written and a practical element and be approved by the State Fire Marshal; amending s. 633.416, F.S.; providing

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/21/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 325 and 326
insert:

Section 7. Section 633.217, Florida Statutes, is created to read:

633.217 Influencing a firesafety inspector; prohibited acts.—

(1) A person may not influence a firesafety inspector by:

(a) Threatening, coercing, tricking, or attempting to

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threaten, coerce, or trick, the firesafety inspector into violating any provision of the Florida Fire Prevention Code, any rule adopted by the State Fire Marshal, or any provision of this chapter.

(b) Offering any compensation to the firesafety inspector to induce a violation of the Florida Fire Prevention Code, any rule adopted by the State Fire Marshal, or any provision of this chapter.

(2) A firesafety inspector may not knowingly and willfully accept an attempt by a person to influence the firesafety inspector into violating any provision of the Florida Fire Prevention Code, any rule adopted by the State Fire Marshal, or any provision of this chapter.

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

And the title is amended as follows:

Delete line 35

and insert:

construction; creating s. 633.217, F.S.; prohibiting certain acts to influence a firesafety inspector into violating certain laws; prohibiting a firesafety inspector from knowingly and willfully accepting an attempt to influence him or her into violating certain laws; amending s. 633.416, F.S.; providing

By Senator Perry

8-00930A-20 20201404__

A bill to be entitled

An act relating to the Department of Financial Services; amending s. 20.121, F.S.; specifying powers and duties of the Division of Public Assistance Fraud; amending s. 497.101, F.S.; revising provisions relating to membership of the Board of Funeral, Cemetery, and Consumer Services; deleting a requirement for the department to adopt certain rules; creating s. 497.1411, F.S.; defining terms; providing for permanent disqualification of applicants for licensure under ch. 497, F.S., for certain offenses; providing for disqualifying periods for applicants for certain offenses; requiring the department to adopt rules; providing for calculation of disqualifying periods; providing conditions for licensure after completion of a disqualifying period; providing for the effect of a pardon or clemency; providing for exemptions from disqualification in certain circumstances; providing procedures for consideration of applications for such exemptions; providing construction; amending s. 497.157, F.S.; prohibiting persons from acting as or advertising themselves as being funeral directors, embalmers, direct disposers, or preneed sales agents unless they are so licensed; prohibiting persons from engaging in certain activities requiring licensure without holding required licenses; providing criminal penalties; amending s. 552.081, F.S.; revising the definition of the term "two-component explosives" for the purpose of

8-00930A-20 20201404__

regulation by the Division of State Fire Marshal; amending s. 553.7921, F.S.; authorizing a contractor repairing certain existing fire alarm systems to begin work after filing an application for a required permit but before receiving the permit; providing construction; amending s. 633.416, F.S.; providing that certain persons serving as volunteer firefighters may serve as a regular or permanent firefighter for a limited period, subject to certain restrictions; amending s. 843.08, F.S.; prohibiting false personation of personnel or representatives of the Division of Investigative and Forensic Services; providing criminal penalties; amending s. 943.045, F.S.; revising the definition of the term "criminal justice agency" to include the investigations component of the department which investigates certain crimes; providing an effective date.

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

Section 1. Paragraph (f) of subsection (2) of section 20.121, Florida Statutes, is amended to read:

20.121 Department of Financial Services.—There is created a Department of Financial Services.

(2) DIVISIONS.—The Department of Financial Services shall consist of the following divisions and office:

(f) The Division of Public Assistance Fraud, which shall function as a criminal justice agency for purposes of ss. 943.045-943.08. The division shall conduct investigations

pursuant to s. 414.411 within or outside of this state as it deems necessary. If, during an investigation, the division has reason to believe that any criminal law of this state has or may have been violated, it shall refer any records tending to show such violation to state or federal law enforcement or prosecutorial agencies and shall provide investigative assistance to those agencies as required.

Section 2. Subsections (1), (2), (3), (6), and (8) of section 497.101, Florida Statutes, are amended to read:

497.101 Board of Funeral, Cemetery, and Consumer Services; membership; appointment; terms.—

(1) The Board of Funeral, Cemetery, and Consumer Services is created within the Department of Financial Services and shall consist of 10 members, 9 of whom shall be appointed by the Governor from nominations made by the Chief Financial Officer and confirmed by the Senate. The Chief Financial Officer shall nominate one to three persons for each of the nine vacancies on the board, and the Governor shall fill each vacancy on the board by appointing one of the ~~three~~ persons nominated by the Chief Financial Officer to fill that vacancy. If the Governor objects to each of the ~~three~~ nominations for a vacancy, she or he shall inform the Chief Financial Officer in writing. Upon notification of an objection by the Governor, the Chief Financial Officer shall submit one to three additional nominations for that vacancy until the vacancy is filled. One member must be the State Health Officer or her or his designee.

(2) Two members of the board shall be funeral directors licensed under part III of this chapter who are associated with a funeral establishment. One member of the board shall be a

funeral director licensed under part III of this chapter who is associated with a funeral establishment licensed under part III of this chapter that has a valid preneed license issued pursuant to this chapter and who owns or operates a cinerator facility approved under chapter 403 and licensed under part VI of this chapter. Two members of the board shall be persons whose primary occupation is associated with a cemetery company licensed pursuant to this chapter. Two ~~Three~~ members of the board shall be consumers who are residents of the state, have never been licensed as funeral directors or embalmers, are not connected with a cemetery or cemetery company licensed pursuant to this chapter, and are not connected with the death care industry or the practice of embalming, funeral directing, or direct disposition. One of the two consumer members shall be at least 60 years of age~~, and one shall be licensed as a certified public accountant under chapter 473~~. One member of the board shall be a consumer who is a resident of this state; is licensed as a certified public accountant under chapter 473; has never been licensed as a funeral director or embalmer; is not a principal or employee of any licensee licensed under this chapter; and does not otherwise have control, as defined in s. 497.005, over any licensee licensed under this chapter. One member of the board shall be a principal of a monument establishment licensed under this chapter as a monument builder. One member shall be the State Health Officer or her or his designee. There shall not be two or more board members who are principals or employees of the same company or partnership or group of companies or partnerships under common control.

(3) Board members shall be appointed for terms of 4 years,

and the State Health Officer shall serve as long as that person holds that office. The designee of the State Health Officer shall serve at the pleasure of the Governor. ~~When the terms of the initial board members expire, the Chief Financial Officer shall stagger the terms of the successor members as follows: one funeral director, one cemetery representative, the monument builder, and one consumer member shall be appointed for terms of 2 years, and the remaining members shall be appointed for terms of 4 years. All subsequent terms shall be for 4 years.~~

(6) The headquarters and records of the board shall be in the Division of Funeral, Cemetery, and Consumer Services of the Department of Financial Services in the City of Tallahassee. The board may be contacted through the Division of Funeral, Cemetery, and Consumer Services of the Department of Financial Services in the City of Tallahassee. The Chief Financial Officer shall annually appoint from among the board members a chair and vice chair of the board. The board shall meet at least every 6 months, and more often as necessary. Special meetings of the board shall be convened upon the direction of the Chief Financial Officer. A quorum is necessary for the conduct of business by the board. Unless otherwise provided by law, a majority of the board members eligible to vote shall constitute a quorum for the purpose of conducting its business ~~six board members shall constitute a quorum for the conduct of the board's business~~.

~~(8) The department shall adopt rules establishing forms by which persons may apply for membership on the board and procedures for applying for such membership. Such forms shall require disclosure of the existence and nature of all current~~

~~and past employments by or contracts with, and direct or indirect affiliations or interests in, any entity or business that at any time was licensed by the board or by the former Board of Funeral and Cemetery Services or the former Board of Funeral Directors and Embalmers or that is or was otherwise involved in the death care industry, as specified by department rule.~~

Section 3. Section 497.1411, Florida Statutes, is created to read:

497.1411 Disqualification of applicants and licensees; penalties against licensees; rulemaking.—

(1) For purposes of this section, the term:

(a) "Applicant" means an individual applying for licensure or relicensure under this chapter, and an officer, a director, a majority owner, a partner, a manager, or other person who manages or controls an entity applying for licensure or relicensure under this chapter.

(b) "Felony of the first degree" and "capital felony" include all felonies designated as such in this state at the time of the commission of the offense, as well as any offense in another jurisdiction that is substantially similar to an offense so designated in this state.

(c) "Financial services business" means any financial activity regulated by the department, the Office of Insurance Regulation, or the Office of Financial Regulation.

(2) An applicant who has been found guilty of or has pleaded guilty or nolo contendere to any of the following crimes, regardless of adjudication, is permanently barred from licensure under this chapter:

(a) A felony of the first degree.

(b) A capital felony.

(c) A felony money laundering offense.

(d) A felony embezzlement.

(3) An applicant who has been found guilty of or has pleaded guilty or nolo contendere to a crime not included in subsection (2), regardless of adjudication, is subject to:

(a) A 10-year disqualifying period for all felonies involving moral turpitude that are not specifically included in the permanent bar contained in subsection (2).

(b) A 5-year disqualifying period for all felonies to which neither the permanent bar in subsection (2) nor the 10-year disqualifying period in paragraph (a) applies.

(c) A 5-year disqualifying period for all misdemeanors directly related to the financial services business.

(4) The department shall adopt rules to administer this section. The rules must provide for additional disqualifying periods due to the commitment of multiple crimes and may include other factors reasonably related to the applicant's criminal history. The rules shall provide for mitigating and aggravating factors. However, mitigation may not result in a period of disqualification of less than 5 years and may not mitigate the disqualifying periods in paragraphs (3)(b) and (c).

(5) For purposes of this section, a disqualifying period begins upon the applicant's final release from supervision or upon completion of the applicant's criminal sentence. The department may not issue a license to an applicant unless all related fines, court costs and fees, and court-ordered restitution have been paid.

(6) After the disqualifying period has expired, the burden is on the applicant to demonstrate that he or she has been rehabilitated, does not pose a risk to the public, is fit and trustworthy to engage in business regulated by this chapter, and is otherwise qualified for licensure.

(7) Notwithstanding subsections (2) and (3), upon a grant of a pardon or the restoration of civil rights pursuant to chapter 940 and s. 8, Art. IV of the State Constitution with respect to a finding of guilt or a plea under subsection (2) or subsection (3), or such pardon or the restoration of civil rights under the laws of another jurisdiction with respect to a conviction in that jurisdiction, such finding or plea no longer bars or disqualifies the applicant from licensure under this chapter; however, such a pardon or restoration of civil rights does not require the department to award such license.

(8)(a) The Board of Funeral, Cemetery, and Consumer Services may grant an exemption from disqualification to any person disqualified from licensure under this section because of a criminal record if:

1. The applicant has paid in full any fee, fine, fund, lien, civil judgment, restitution, or cost of prosecution imposed by the court as part of the judgment and sentence for any disqualifying offense; and

2. At least 5 years have elapsed since the applicant completed or has been lawfully released from confinement, supervision, or nonmonetary condition imposed by the court for a disqualifying offense.

(b) For the board to grant an exemption under this subsection, the applicant must clearly and convincingly

demonstrate that he or she would not pose a risk to persons or property if licensed under this chapter, evidence of which must include, but need not be limited to, facts and circumstances surrounding the disqualifying offense, the time that has elapsed since the offense, the nature of the offense and harm caused to the victim, the applicant's history before and after the offense, and any other evidence or circumstances indicating that the applicant will not present a danger if licensed or certified.

(c) The board has discretion whether to grant or deny an exemption under this subsection. The board's decision is subject to chapter 120, except that a formal proceeding under s. 120.57(1) is available only if there are disputed issues of material fact that the department relied upon in reaching its decision.

Section 4. Present subsections (2) through (5) of section 497.157, Florida Statutes, are redesignated as subsections (4) through (7), respectively, new subsections (2) and (3) and subsection (8) are added to that section, and present subsection (3) of that section is amended, to read:

497.157 Unlicensed practice; remedies concerning violations by unlicensed persons.—

(2) A person may not be, act as, or advertise or hold himself or herself out to be a funeral director, embalmer, or direct disposer unless he or she is currently licensed by the department.

(3) A person may not be, act as, or advertise or hold himself or herself out to be a preneed sales agent unless he or she is currently licensed by the department and appointed by a

preneed main licensee for which they are executing preneed contracts.

(5)~~(3)~~ Where the department determines that an emergency exists regarding any violation of this chapter by any unlicensed person or entity, the department may issue and serve an immediate final order upon such unlicensed person or entity, in accordance with s. 120.569(2)(n). Such an immediate final order may impose such prohibitions and requirements as are reasonably necessary to protect the public health, safety, and welfare, and shall be effective when served.

(a) For the purpose of enforcing such an immediate final order, the department may file an emergency or other proceeding in the circuit courts of the state seeking enforcement of the immediate final order by injunctive or other order of the court. The court shall issue its injunction or other order enforcing the immediate final order pending administrative resolution of the matter under subsection (4) ~~(2)~~, unless the court determines that such action would work a manifest injustice under the circumstances. Venue for judicial actions under this paragraph shall be, at the election of the department, in the courts of Leon County, or in a county where the respondent resides or has a place of business.

(b) After serving an immediate final order to cease and desist upon any person or entity, the department shall within 10 days issue and serve upon the same person or entity an administrative complaint as set forth in subsection (4) ~~(2)~~, except that, absent order of a court to the contrary, the immediate final order shall be effective throughout the pendency of proceedings under subsection (4) ~~(2)~~.

(8) Any person who is not licensed under this chapter and who engages in activity requiring licensure under this chapter commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 5. Subsection (13) of section 552.081, Florida Statutes, is amended to read:

552.081 Definitions.—As used in this chapter:

(13) "Two-component explosives" means any two inert components which, when mixed, become capable of detonation by any detonator ~~a No. 6 blasting cap~~, and shall be classified as a Class "A" explosive when so mixed.

Section 6. Present subsection (2) of section 553.7921, Florida Statutes, is redesignated as subsection (3), a new subsection (2) is added to that section, and subsection (1) of that section is amended, to read:

553.7921 Fire alarm permit application to local enforcement agency.—

(1) A contractor must file a Uniform Fire Alarm Permit Application as provided in subsection (3) ~~(2)~~ with the local enforcement agency and must receive the fire alarm permit before~~:~~

~~(a)~~ installing or replacing a fire alarm, if the local enforcement agency requires a plan review for the installation or replacement~~; or~~

~~(b) Repairing an existing alarm system that was previously permitted by the local enforcement agency if the local enforcement agency requires a fire alarm permit for the repair~~.

(2) If the local enforcement agency requires a fire alarm permit to repair an existing alarm system that was previously

permitted by the local enforcement agency, a contractor may begin work after filing a Uniform Fire Alarm Permit Application as provided in subsection (3). A fire alarm repaired pursuant to this subsection may not be considered compliant until the required permit is issued and the local enforcement agency approves the repair.

Section 7. Subsection (1) of section 633.416, Florida Statutes, is amended to read:

633.416 Firefighter employment and volunteer firefighter service; saving clause.—

(1) A fire service provider may not employ an individual to:

(a) Extinguish fires for the protection of life or property or to supervise individuals who perform such services unless the individual holds a current and valid Firefighter Certificate of Compliance. However, a person who is currently serving as a volunteer firefighter and holds a volunteer firefighter certificate of completion with a fire service provider, who is then employed as a regular or permanent firefighter by such fire service provider, may function, for a period of 1 year under the direct supervision of an individual holding a valid firefighter certificate of compliance, in the same capacity in which he or she acted as a volunteer firefighter, provided that he or she has completed all training required by the volunteer organization. Under no circumstance can this period extend beyond 1 year either collectively or consecutively from the start of employment to obtain a Firefighter Certificate of Compliance; or

(b) Serve as the administrative and command head of a fire

service provider for a period in excess of 1 year unless the individual holds a current and valid Firefighter Certificate of Compliance or Special Certificate of Compliance.

Section 8. Section 843.08, Florida Statutes, is amended to read:

843.08 False personation.—A person who falsely assumes or pretends to be a firefighter, a sheriff, an officer of the Florida Highway Patrol, an officer of the Fish and Wildlife Conservation Commission, an officer of the Department of Environmental Protection, ~~a fire or arson investigator of the Department of Financial Services,~~ an officer of the Department of Financial Services, any personnel or representative of the Division of Investigative and Forensic Services, an officer of the Department of Corrections, a correctional probation officer, a deputy sheriff, a state attorney or an assistant state attorney, a statewide prosecutor or an assistant statewide prosecutor, a state attorney investigator, a coroner, a police officer, a lottery special agent or lottery investigator, a beverage enforcement agent, a school guardian as described in s. 30.15(1)(k), a security officer licensed under chapter 493, any member of the Florida Commission on Offender Review or any administrative aide or supervisor employed by the commission, any personnel or representative of the Department of Law Enforcement, or a federal law enforcement officer as defined in s. 901.1505, and takes upon himself or herself to act as such, or to require any other person to aid or assist him or her in a matter pertaining to the duty of any such officer, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. However, a person who

falsely personates any such officer during the course of the commission of a felony commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the commission of the felony results in the death or personal injury of another human being, the person commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 9. Paragraph (f) is added to subsection (11) of section 943.045, Florida Statutes, to read:

943.045 Definitions; ss. 943.045-943.08.—The following words and phrases as used in ss. 943.045-943.08 shall have the following meanings:

(11) "Criminal justice agency" means:

(f) The investigations component of the Department of Financial Services which investigates the crimes of fraud and official misconduct in all public assistance given to residents of the state or provided to others by the state.

Section 10. This act shall take effect July 1, 2020.

Department of Financial Services (DFS)
2020 Legislative Bill Analysis

BILL INFORMATION

Bill Number:	SB 1404
Bill Title:	Department of Financial Services
Sponsor:	Perry
Effective Date:	July 1, 2020

ANALYSIS INFORMATION

Agency Contact:	Meredith Stanfield, Legislative Affairs Director, (850) 413-2890
Division Director:	Jack Heacock, Julius Halas, Mary Schwantes, Simon Blank
Program Analyst:	Ellie Simon, Casia Sinco, Austin Stowers
Analysis Date:	January 14, 2020

POLICY ANALYSIS

I. SUMMARY ANALYSIS

SB 1404 is the 2020 Legislative Package for the Department of Financial Services (DFS or Department). This bill protects Floridians from fraud and criminal activity of individuals or organizations who aim to take advantage of them. The bill clarifies sections of statute for the following DFS Divisions: Investigative and Forensic Services (DIFS), Public Assistance Fraud (PAF), Funeral, Cemetery, and Consumer Services (FCCS), and State Fire Marshal (SFM). Specifically, the bill:

- clarifies statute to designate PAF as a criminal justice agency. This division transferred from the Florida Department of Law Enforcement in 2005, and though they operate as a criminal justice agency, statute was not appropriately amended to reflect at the time of the move. Maintaining this designation is critical to our work to fight public assistance fraud;
- provides changes to the Board of FCCS, including the definition of a quorum, cleans up the application rule making process, removes unnecessary term staggering requirements, and provides clarification on Board member requirements;
- establishes disqualification provisions for the Board of FCCS applicants based on criminal history;
- strengthens DFS' ability to fight unlicensed activity by adding provisions to make unlicensed funeral activity a felony rather than misdemeanor;
- clarifies the definition of "two-component explosive" in s. 552.081(13), F.S., to reference any detonator rather than the specific "No. 6 blasting cap";
- allows a previously permitted fire alarm needing repairs to have expedited repairs, still ensuring that the system is permitted and approved by the local enforcement agency;
- correct the clause that disallows a certified volunteer firefighter who is transitioning to a regular or permanent firefighter from continuing to serve their communities during training; and,
- clarifies statute regarding false impersonation of law enforcement officers to include all DIFS officers rather than a subset.

II. PRESENT SITUATION

Sections 1 and 9:
PAF has operated as a criminal justice agency since its inception in 1972. When DIFS was created in 2016, the change to Chapter 20, F.S., left PAF undefined in regard its status as a criminal justice agency. Currently, the Chief Financial Officer (CFO) has the responsibility to investigate public assistance given to citizens of Florida or given to others by Florida. By strict interpretation of existing statutes, PAF operates as a criminal justice agency however, further clarification provides a greater level of protection for Florida's citizens and DFS.

Section 2:
The Board of FCCS (the Board) is currently comprised of ten members, nine of which are appointed by the Governor from nominations made by the CFO. The CFO makes three recommendations for each vacancy, but the current statutory scheme does not provide for the possibility that the CFO does not receive three or more applications for qualified applicants, which often occurs.

The Board position that is filled by a Certified Public Accountant (CPA) requires that the CPA not be associated with the death care industry. In the past few years, very few have applied for this position, possibly due to this non-association requirement. The position has remained vacant since September 2017.

The presence of six members is considered a quorum to conduct the business of the Board. This is a specific number which can be difficult to obtain when Board positions remain vacant, Board members are absent, or members must recuse themselves from voting on a matter.

Current board requirements provide for the staggered terms of the initial Board positions. This provision is no longer needed as the Board is now well established and the positions, having already been staggered at the initiation of the Board, do not now become vacant at the same time.

DFS is required to adopt rules regarding the application forms and procedures for appointment to the Board. However, since Board appointments are made by the Governor, there is no need for a Department created rule on these matters.

Section 3:
Section 497.1411, F.S., currently lacks clarity regarding the crimes for which a person may be disqualified from licensure under Chapter 497, F.S., and significantly limits the ability to disqualify applicants from licensure based upon criminal background. New applicants are required to disclose all felonies committed within the 20 years preceding the application and felonies committed outside the 20 year period if they were related to the death care industry functions requiring licensure under Chapter 497, F.S. New applicants are also required to disclose misdemeanors committed within 5 years preceding the application, and any misdemeanor outside the 20 year period if they were related to the death care industry functions requiring licensure under Chapter 497, F.S.

The applicants criminal background is reviewed by FCCS staff prior to presenting the application to the Board for approval. Those applicants with felonies or misdemeanors within the respective 20 and 5 year time frames are presented to the Board with recommendations to approve or deny the applicant. The presentation and treatment of applications from those who have felonies or misdemeanors that fall outside of those required reporting periods varies, primarily depending upon the nature of the felony or misdemeanor. Board rulings have varied significantly over the years on both new applications and renewal applications for which the Division has recommended denial.
The current statutory scheme provides no guidelines if a specific crime is considered "directly or indirectly related to or involving any aspect of the practice or business" of death care industry functions. Similarly, the current statutory scheme does not provide specific discretion for the Board to consider a crime that is unrelated to the

death care industry practice when approving or disapproving licensure. This lack of clarity and guidance has led to inconsistencies in recommendations and Board rulings on applications.

Section 4:
Chapter 497, F.S., requires individuals to maintain a license for specified death care industry practices. Specific examples of unlicensed practice are not included and section 497.157, F.S., does not provide a penalty for unlicensed activity. Section 497.159, F.S., provides a penalty for some unlicensed activity, but is limited to a second-degree misdemeanor for individuals who have no license under Chapter 497, F.S.

Section 5:
Chapter 552, F.S., addresses the manufacture, distribution and use of explosives. Current definition of a two-component explosive requires the use of a "No. 6 blasting cap". No. 6 blasting caps went out of production several years ago and current blasting caps no longer use the same rating system.

Section 6:
Contractors are required to file a Uniform Fire Alarm Permit Application with the local enforcement agency and receive a permit prior to installing and replacing systems, and before they repair an existing alarm system that has been permitted in the past, if such permits are required by the local enforcement agency for repairs.

Section 7:
Individuals currently certified with a Firefighter Certificate of Completion (volunteer firefighters) can enter immediately dangerous to life and health (IDLH) environments. However, if employed by the same department prior to achieving a Firefighter Certificate of Compliance (career firefighters) they would not be allowed to enter the IDLH environments they were authorized to enter the day before beginning career employment.

Section 8:
DIFS law enforcement officers and personnel respond to high pressure situations to protect Floridians from fraud, misuse of state funds, theft, arson, and explosives. It is currently against the law to impersonate fire or arson investigators of the Department. The impersonation of an officer under section 843.08, F.S., commits a felony of the third degree, second degree when committed with another felony, and the first degree if the felony is the cause of death or personal injury of another individual.

III. EFFECT OF PROPOSED CHANGES

Sections 1 and 9:
The proposed changes in section 20.121, F.S., establish the status of criminal justice agency for PAF, allowing it to continue to function appropriately in the execution of its fraud investigation mission. The designation allows the criminal investigations and other law enforcement support functions to continue having access to criminal justice information contained in FCIC and NCIC systems of criminal records. DPAF meets the criteria for criminal justice agency as defined in sections 943.045-943.08, F.S., specifically subsection 943.045(2) and paragraph 943.045(11)(e), F.S.

Section 2:
This section would clarify the number of nominees which the CFO must submit to the Governor for each vacant position of the Board of FCCSS. As proposed, the Chief Financial Officer would nominate one to three persons for each of the vacancies.
Clarification of the requirements regarding the Board position of CPA will require the position to be filled by a Florida licensed Certified Public Accountant who has never been licensed as a funeral director or embalmer, is not a principal or employee of any Chapter 497, F.S., licensee, and does not otherwise have control (as defined in section 497.005, F.S.) over any Chapter 497, F.S., licensee. This change will permit a CPA who has some knowledge

of and association with the death care industry (e.g., the CPA has funeral home clients) to be appointed to the Board as long as the CPA also meets the other referenced requirements. These requirements in places will limit the degree of business investments the CPA may have in the death care industry while still promoting the appointment of a knowledgeable, fair, and unbiased Board member.

This section will also amend the statutory definition of a quorum for conducting the Board business to providing that the quorum consists of the majority of the Board members eligible to vote. The section will also eliminate unnecessary statutory provisions regarding the staggered terms of Board members, which have already been established. The statutory change will also eliminate DFS rulemaking concerning the application process, which is unnecessary, as the Governor makes the appointments.

Section 3:
The bill would create section 497.1411, F.S., to establish procedures and disqualifications for applicants and licensees under Chapter 497, F.S., including:

- Disqualification of applicants based upon criminal history, providing guidelines as to the types of crimes for which an applicant may be disqualified;
- Consideration and examination of applicants with a criminal background;
- Permanent bars and disqualification periods of 5-10 years;
- Rulemaking authority for the purposes of implementation.;
- Requirements for applicants to demonstrate, after an applicable disqualifying period, that they are qualified for licensure;
- That a grant, pardon, or restoration of civil rights for a crime delineated by this section results in the crime not being a bar to licensure; and
- The authority of the Board of FCCS to grant exemptions to the disqualifications to licensure if applicants present mitigating circumstances.

Section 4:
The bill would establish specific penalties for unlicensed activity for persons not licensed under Chapter 497, F.S., who engage in activity requiring licensure, commits a felony of the third degree. Additional criteria are established to constitute unlicensed practices under Chapter 497, F.S., including advertisement as a licensee when the person does not hold a license from the Department.

Section 5:
This section would update the definition of a two-component explosive to eliminate the requirement that the mixture be capable of being detonated by a “No. 6” blasting cap but rather that the mixture be capable of detonation by “any detonator” (nonspecific). As the “No. 6” blasting cap is no longer in production, the amendment to this section simply brings the language in line with current practices.

Section 6:
This section will amend section 553.7921, F.S., allowing contractors to begin repairs on a previously permitted fire alarm system in an expedient manner. The contractor completing the repairs will still be required to file a Uniform Fire Alarm Permit Application to the local enforcement agency prior to beginning the repairs, but they will not be required to receive the fire alarm permit before beginning the repairs. The repaired fire alarm system will not be considered compliant until the appropriate permit is received, and the local enforcement agency approves the repairs made.

Section 7:
This section would allow Fire Service Providers to transition qualified personnel from volunteer status to career. This change would improve rural and small agency recruitment and retention efforts as it would allow them to

focus on hiring from local candidates who are more inclined to remain in the area instead of hiring candidates from elsewhere in the state who are inclined to return to their home communities once gaining some experience.

Section 8:
This section would amend section 843.08, F.S., relating to DIFS personnel who have access to active criminal cases and conduct criminal investigations. Rather than protecting a subsection of investigators and officers within the Department, this section would make it a felony to impersonate any DIFS personnel and/or Department officers.

IV. DOES THE BILL DIRECT OR ALLOW THE DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? **Y☒ N☐**

If yes, explain:	The amendments to section 497.101, F.S., may result in the elimination of a requirement for rules/forms regarding the Board application process. The creation of section 497.1411, F.S., would result in a requirement that rules be developed to implement the section.
Is the change consistent with the agency's core mission?	**Y☒ N☐**
Rule(s) impacted (provide references to F.A.C.):	

V. DOES THE BILL REQUIRE REPORTS OR STUDIES? **Y☐ N☒**

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

VI. DOES THE BILL REQUIRE APPOINTMENTS OR MODIFY EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSIONS, ETC.? **Y☒ N☐**

Board:	Board of Funeral, Cemetery, and Consumer Services
Board Purpose:	Oversight/regulation of the death care industry as set out in Chapter 497, F.S.
Who Appoints:	Governor appoints 9 of the 10 positions on the Board. The remaining position is held by the State Health Officer or his/her designee.
Changes:	While the proposed bill would not modify the composition or responsibilities of the Board itself, it would provide additional parameters for the consumer position on the Board which is filled by a CPA and changes quorum requirements for the Board to conduct business.
Bill Section Number(s):	Section 2

FISCAL ANALYSIS

I. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? **Y☐ N☒**

Revenues:	
Expenditures:	

II. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y☐ N☒

Revenues:	
Expenditures:	
Does the legislation contain a State Government appropriation?	
If yes, was this appropriated last year?	

III. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y☐ N☒

Revenues:	
Expenditures:	
Other:	

IV. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y☐ N☒

If yes, explain impact.	
Bill Section Number:	

TECHNOLOGY IMPACT

I. DOES THE BILL IMPACT THE DEPARTMENT'S TECHNOLOGY SYSTEMS (I.E., IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y☐ N☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	

FEDERAL IMPACT

I. DOES THE BILL HAVE A FEDERAL IMPACT (I.E., FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y☐ N☒

If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	Rules: The proposed legislation requires the Department to promulgate rules to administer proposed section 497.1411, Florida Statutes, relating to disqualification of applicants and licensees and penalties against licensees.

THE FLORIDA SENATE

APPEARANCE RECORD

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

1-21-20
Meeting Date

1404
Bill Number (if applicable)

Topic Dept. of Financial Services

265294
Amendment Barcode (if applicable)

Name Jim Millican

Job Title Chief

Address 4360-55 Ave N
Street

Phone 727 586 5650

St. Pete FL 33714
City *State* *Zip*

Email jmillican@leolmonfire.us

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Fire Chiefs & Florida Fire Marshals

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/21
Meeting Date

1404
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Department of Financial Services

Name Meredith Stanfield

Job Title Director of Legislative & Cabinet Affairs

Address PL 11, The Capitol
Street

Tallahassee FL 32399
City *State* *Zip*

Phone (850) 413-2890

Email meredith.stanfield@myfloridaCFO.com

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

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

Representing The Department of Financial Services

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

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

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THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

1404
Bill Number (if applicable)

Topic FUNERAL CEMETERY

Amendment Barcode (if applicable)

Name SCOTT (WHITEHEAD)

Job Title CHAIR INDIPENT FUNERAL DIRECTORS

Address 6972 FL/GA HWY
Street

HAVANA, FL 32333
City State Zip

Phone

Email

Speaking: ☑ For ☐ Against ☐ Information

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

Representing IFDF

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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THE FLORIDA SENATE

APPEARANCE RECORD

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

1-21-20
Meeting Date

SB 1404
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Gary Rutledge

Job Title _____

Address 641 Forest Lair
Street

Tallahassee FL 32317
City *State* *Zip*

Phone 850-509-4995

Email GaryRutledge@earthlink.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing ADT

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.

CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Banking and Insurance Committee **Judge:**

Started: 1/21/2020 12:04:44 PM
Ends: 1/21/2020 1:25:01 PM **Length: 01:20:18**

12:04:47 PM Meeting called to order by Chair - quorum present.
12:05:39 PM Senator Rouson takes the Chair
12:05:46 PM TAB 6 s 1376 by Broxson Credit for Reinsurance
12:06:07 PM Sen. Broxson recognized to explain the bill.
12:06:33 PM Susanne Murphy - Office of Insurance Regulation
12:07:27 PM George Feijoo, FL Insur. Council
12:07:49 PM Roll call on S 1376 - Favorable
12:08:34 PM TAB 3 S 1006 by Sen Baxley - Coverage for Hearing Aids for Children
12:09:34 PM Sen. Baxley recognized to explain the bill.
12:10:27 PM Harvey Rhinehart
12:15:17 PM Garrett Campbell rep. Self
12:16:17 PM Jerrod Fowler, FL Medical Association
12:17:49 PM Roll call vote on SB 1006 - Favorable
12:18:23 PM TAB 4 - S 1224 Sen. Simmons and Gruters
12:19:18 PM Senator Gruters explains the bill.
12:19:38 PM Senator Lee with question on bill.
12:20:40 PM Roll call vote on S 1224 - Favorable
12:21:26 PM TAB 4 - S 914 by Brandes - Property Insurance
12:21:43 PM Senator Brandes explains the bill.
12:22:46 PM Question by Senator Rouson.
12:23:46 PM Question on AMD. 806840 by Sen. Rouson
12:24:29 PM Followup question by Sen. Rouson on amendment.
12:26:40 PM Senator Thurston with question of Sponsor.
12:27:55 PM Aram Megerian, FL Justice Reform Institute -speaking on amd. 806840
12:31:59 PM Sen. Rouson with question for speaker
12:34:38 PM Sen. Thurston with question of speaker.
12:37:01 PM Sen. Lee with question of speaker.
12:40:26 PM Sen. Broxson with question of speaker.
12:50:51 PM Amy Boggs, Chair of Florida Justice Assoc.
12:51:52 PM
12:52:35 PM Sen. Taddeo with question of speaker.
12:52:38 PM Sen. Taddeo with followup questions of speaker.
12:53:41 PM Sen. Gruters recognized for question of speaker.
12:56:56 PM Sen. Thurston with question of speaker.
12:58:51 PM Time certain motion by Sen. Perry- 1:05 --passed
1:00:20 PM
1:01:09 PM Chip Merlin-Merlin Law Firm
1:01:26 PM Sen. Rouson with comment to vote against bill.
1:02:55 PM Sen. Lee speaks in support of bill.
1:03:48 PM Sen. Brandes to close on bill.
1:04:55 PM Comments by Chair.
1:05:01 PM Roll call vote on CS/SB 914 - Favorable
1:05:34 PM TAB 7 S 1404 by Perry - Dept. of Financial Services
1:05:53 PM Sen. Perry explains the bill.
1:06:01 PM Sen. Perry explains the amendment.
1:06:32 PM Voice Vote on Amend. -Adopted
1:07:02 PM Roll call vote on CS/SB 1404 - Favorable
1:07:43 PM TAB 1 - S 736 by Sen. Diaz - Coverage for Air Ambulance Services
1:08:10 PM Sen. Diaz recognized to explain the bill.
1:08:58 PM AMD. 198296 (tech. amend.) voice vote-- favorable
1:09:42 PM Senator Rouson with question on bill.
1:11:12 PM Jim Millican, FL Fire Chiefs Assoc.

1:14:05 PM Sen. Thurston with question of speaker.
1:15:01 PM Sen. Brandes with question from speaker.
1:15:45 PM Steve Hudson, Deputy Chief - Monroe County Fire
1:21:07 PM Motion by Sen. Rouson for time certain vote at 1:29.-passed
1:22:50 PM Debate on S 736.
1:23:35 PM Senator Diaz closes on bill.
1:23:48 PM Roll call vote on CS.S 736 -favorable
1:24:35 PM
1:24:36 PM Meeting adjourned on motion of Sen. Teddeo.